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8 UNITED STATES DISTRICT COURT  
9 CENTRAL DISTRICT OF CALIFORNIA  
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11 LYNNE A. DEVOE, ) Case No. EDCV 17-0299-JPR  
12 )  
13 Plaintiff, )  
14 ) MEMORANDUM DECISION AND ORDER  
15 v. ) AFFIRMING COMMISSIONER  
16 )  
17 NANCY A. BERRYHILL, Acting )  
18 Commissioner of Social )  
19 Security, )  
20 )  
21 Defendant. )  
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1 **II. BACKGROUND**

2 Plaintiff was born in 1974. (Administrative Record ("AR")  
3 85, 100.) She completed 12th grade (AR 217) and last worked in  
4 construction and as a restaurant server (see AR 54, 66, 217).

5 In November 2012, Plaintiff filed an application for DIB,  
6 alleging that she had been disabled since July 21, 2011, because  
7 of scoliosis; a herniated disk; spinal stenosis; fibromyalgia;  
8 numbness in her right neck, shoulder, and arm; headaches;  
9 insomnia; anxiety; and depression. (See AR 85, 100, 196.) After  
10 her application was denied initially (AR 114-17) and on  
11 reconsideration (AR 119-23), she requested a hearing before an  
12 Administrative Law Judge (AR 126-27). A hearing was scheduled  
13 for June 3, 2015, but Plaintiff did not appear. (See AR 20; see  
14 also AR 135-46 (Apr. 15, 2015 notice of June 3 hearing), 147-48  
15 (May 2, 2015 acknowledgment of receipt of notice of hearing), 149  
16 (May 20, 2015 reminder of hearing), 151-53 (June 5, 2015 request  
17 to show cause for failure to appear at hearing), 154-55  
18 (Plaintiff's June 18, 2015 response).)

19 A hearing was held on October 26, 2015. (AR 72-84.)  
20 Plaintiff this time appeared but was not represented by an  
21 attorney or other acceptable representative. (See AR 76-77.)  
22 The ALJ continued the hearing so that Plaintiff could obtain  
23 representation. (See AR 171.) A supplemental hearing was then  
24 held on January 28, 2016, at which Plaintiff, who was now  
25 represented by counsel, testified, as did a vocational expert.  
26 (AR 40-71.) In a written decision issued February 18, 2016, the  
27 ALJ found Plaintiff not disabled. (AR 20-39.) Plaintiff  
28 requested review from the Appeals Council (AR 14), and on January

17, 2017, it denied review (AR 1-6). This action followed.

### III. STANDARD OF REVIEW

Under 42 U.S.C. § 405(g), a district court may review the Commissioner's decision to deny benefits. The ALJ's findings and decision should be upheld if they are free of legal error and supported by substantial evidence based on the record as a whole. See id.; Richardson v. Perales, 402 U.S. 389, 401 (1971); Parra v. Astrue, 481 F.3d 742, 746 (9th Cir. 2007). Substantial evidence means such evidence as a reasonable person might accept as adequate to support a conclusion. Richardson, 402 U.S. at 401; Lingenfelter v. Astrue, 504 F.3d 1028, 1035 (9th Cir. 2007). It is more than a scintilla but less than a preponderance. Lingenfelter, 504 F.3d at 1035 (citing Robbins v. Soc. Sec. Admin., 466 F.3d 880, 882 (9th Cir. 2006)). To determine whether substantial evidence supports a finding, the reviewing court "must review the administrative record as a whole, weighing both the evidence that supports and the evidence that detracts from the Commissioner's conclusion." Reddick v. Chater, 157 F.3d 715, 720 (9th Cir. 1998). "If the evidence can reasonably support either affirming or reversing," the reviewing court "may not substitute its judgment" for the Commissioner's. Id. at 720-21.

### IV. THE EVALUATION OF DISABILITY

People are "disabled" for purposes of receiving Social Security benefits if they are unable to engage in any substantial gainful activity owing to a physical or mental impairment that is expected to result in death or has lasted, or is expected to last, for a continuous period of at least 12 months. 42 U.S.C. § 423(d)(1)(A); Drouin v. Sullivan, 966 F.2d 1255, 1257 (9th Cir.

1 1992).

2 A. The Five-Step Evaluation Process

3 The ALJ follows a five-step sequential evaluation process to  
4 assess whether a claimant is disabled. 20 C.F.R.

5 § 404.1520(a)(4); Lester v. Chater, 81 F.3d 821, 828 n.5 (9th  
6 Cir. 1995) (as amended Apr. 9, 1996). In the first step, the  
7 Commissioner must determine whether the claimant is currently  
8 engaged in substantial gainful activity; if so, the claimant is  
9 not disabled and the claim must be denied. § 404.1520(a)(4)(i).

10 If the claimant is not engaged in substantial gainful  
11 activity, the second step requires the Commissioner to determine  
12 whether the claimant has a "severe" impairment or combination of  
13 impairments significantly limiting her ability to do basic work  
14 activities; if not, the claimant is not disabled and her claim  
15 must be denied. § 404.1520(a)(4)(ii).

16 If the claimant has a "severe" impairment or combination of  
17 impairments, the third step requires the Commissioner to  
18 determine whether the impairment or combination of impairments  
19 meets or equals an impairment in the Listing of Impairments set  
20 forth at 20 C.F.R. part 404, subpart P, appendix 1; if so,  
21 disability is conclusively presumed. § 404.1520(a)(4)(iii).

22 If the claimant's impairment or combination of impairments  
23 does not meet or equal an impairment in the Listing, the fourth  
24 step requires the Commissioner to determine whether the claimant  
25 has sufficient residual functional capacity ("RFC")<sup>1</sup> to perform

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27 <sup>1</sup> RFC is what a claimant can do despite existing exertional  
28 and nonexertional limitations. § 404.1545; see Cooper v.  
Sullivan, 880 F.2d 1152, 1155 n.5 (9th Cir. 1989). The

1 her past work; if so, she is not disabled and the claim must be  
2 denied. § 404.1520(a)(4)(iv). The claimant has the burden of  
3 proving she is unable to perform past relevant work. Drouin, 966  
4 F.2d at 1257. If the claimant meets that burden, a prima facie  
5 case of disability is established. Id.

6 If that happens or if the claimant has no past relevant  
7 work, the Commissioner then bears the burden of establishing that  
8 the claimant is not disabled because she can perform other  
9 substantial gainful work available in the national economy.

10 § 404.1520(a)(4)(v); Drouin, 966 F.2d at 1257. That  
11 determination comprises the fifth and final step in the  
12 sequential analysis. § 404.1520(a)(4)(v); Lester, 81 F.3d at 828  
13 n.5; Drouin, 966 F.2d at 1257.

14 B. The ALJ's Application of the Five-Step Process

15 At step one, the ALJ found that Plaintiff had not engaged in  
16 substantial gainful activity since July 21, 2011, the alleged  
17 disability-onset date. (AR 23.) At step two, he concluded that  
18 she had one severe impairment: degenerative disc disease of the  
19 lumbar spine. (Id.) At step three, he found that she did not  
20 have an impairment or combination of impairments falling under a  
21 Listing. (AR 27.)

22 At step four, the ALJ found that Plaintiff had the RFC to  
23 perform medium work. (Id.) Based on the VE's testimony, the ALJ  
24 concluded that Plaintiff could perform her past relevant work as  
25 a server. (AR 32.) Thus, the ALJ found Plaintiff not disabled.

26 \_\_\_\_\_  
27 Commissioner assesses the claimant's RFC between steps three and  
28 four. Laborin v. Berryhill, 867 F.3d 1151, 1153 (9th Cir. 2017)  
(citing § 416.920(a)(4)).

1 (Id.)

2 **V. DISCUSSION**

3 Plaintiff argues that the ALJ erred in finding that she had  
4 no severe mental impairment (J. Stip. at 4-10, 15-18), evaluating  
5 her physical impairments (id. at 18-21, 24-26), and rejecting her  
6 subjective symptom testimony (id. at 26-27, 31-33). Plaintiff  
7 also raises several challenges to the ALJ's evaluation of the  
8 medical-opinion evidence. (See id. at 5-7, 8-10, 15-18, 20-21,  
9 24-26.) For efficiency, the Court addresses Plaintiff's  
10 arguments in an order different from that followed by the  
11 parties. As discussed below, the ALJ did not err and remand is  
12 not warranted.

13 A. The ALJ Properly Evaluated Plaintiff's Subjective  
14 Symptom Testimony

15 The ALJ found Plaintiff's allegations "less than fully"  
16 credible. (AR 29.) She contends that that was in error (J.  
17 Stip. at 26) and specifically challenges the ALJ's reliance on  
18 her supposedly "minimal activities of daily living" (id. at 27)  
19 and "lack of treatment that [was] more aggressive" (id. at 26).  
20 The ALJ did not err in either regard, however, and offered an  
21 additional reason unchallenged by Plaintiff: her subjective  
22 symptom statements were unsupported by the medical evidence. (AR  
23 29.) Accordingly, remand is unwarranted on this ground.

24 1. Applicable law

25 An ALJ's assessment of the credibility of a claimant's  
26 allegations concerning the severity of her symptoms is entitled  
27 to "great weight." See Weetman v. Sullivan, 877 F.2d 20, 22 (9th  
28 Cir. 1989) (as amended); Nyman v. Heckler, 779 F.2d 528, 531 (9th

1 Cir. 1985) (as amended Feb. 24, 1986). "[T]he ALJ is not  
2 'required to believe every allegation of disabling pain, or else  
3 disability benefits would be available for the asking, a result  
4 plainly contrary to 42 U.S.C. § 423(d)(5)(A).'" Molina v.  
5 Astrue, 674 F.3d 1104, 1112 (9th Cir. 2012) (quoting Fair v.  
6 Bowen, 885 F.2d 597, 603 (9th Cir. 1989)).

7 In evaluating a claimant's subjective symptom testimony, the  
8 ALJ engages in a two-step analysis. See Lingenfelter, 504 F.3d  
9 at 1035-36; see also SSR 96-7p, 1996 WL 374186 (July 2, 1996).<sup>2</sup>  
10 "First, the ALJ must determine whether the claimant has presented  
11 objective medical evidence of an underlying impairment [that]  
12 could reasonably be expected to produce the pain or other  
13 symptoms alleged." Lingenfelter, 504 F.3d at 1036. If such  
14 objective medical evidence exists, the ALJ may not reject a  
15 claimant's testimony "simply because there is no showing that the  
16 impairment can reasonably produce the degree of symptom alleged."  
17 Smolen v. Chater, 80 F.3d 1273, 1282 (9th Cir. 1996) (emphasis in  
18 original).

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20 <sup>2</sup> Social Security Ruling 16-3p, 2016 WL 1119029, effective  
21 March 16, 2016, rescinded SSR 96-7p, which provided the framework  
22 for assessing the credibility of a claimant's statements. SSR  
23 16-3p was not in effect at the time of the ALJ's decision in this  
24 case, however, and therefore does not apply. Still, the Ninth  
25 Circuit has clarified that SSR 16-3p "makes clear what our  
26 precedent already required: that assessments of an individual's  
27 testimony by an ALJ are designed to 'evaluate the intensity and  
28 persistence of symptoms after [the ALJ] find[s] that the  
individual has a medically determinable impairment(s) that could  
reasonably be expected to produce those symptoms,' and not to  
delve into wide-ranging scrutiny of the claimant's character and  
apparent truthfulness." Trevizo v. Berryhill, 871 F.3d 664, 678  
n.5 (9th Cir. 2017) (as amended) (alterations in original)  
(quoting SSR 16-3p).

1 If the claimant meets the first test, the ALJ may discredit  
2 the claimant's subjective symptom testimony only if he makes  
3 specific findings that support the conclusion. See Berry v.  
4 Astrue, 622 F.3d 1228, 1234 (9th Cir. 2010). Absent a finding or  
5 affirmative evidence of malingering, the ALJ must provide "clear  
6 and convincing" reasons for rejecting the claimant's testimony.  
7 Brown-Hunter v. Colvin, 806 F.3d 487, 493 (9th Cir. 2015) (as  
8 amended); Treichler v. Comm'r of Soc. Sec. Admin., 775 F.3d 1090,  
9 1102 (9th Cir. 2014). The ALJ may consider, among other factors,  
10 (1) ordinary techniques of credibility evaluation, such as the  
11 claimant's reputation for lying, prior inconsistent statements,  
12 and other testimony by the claimant that appears less than  
13 candid; (2) unexplained or inadequately explained failure to seek  
14 treatment or to follow a prescribed course of treatment; (3) the  
15 claimant's daily activities; (4) the claimant's work record; and  
16 (5) testimony from physicians and third parties. Rounds v.  
17 Comm'r Soc. Sec. Admin., 807 F.3d 996, 1006 (9th Cir. 2015) (as  
18 amended); Thomas v. Barnhart, 278 F.3d 947, 958-59 (9th Cir.  
19 2002). If the ALJ's credibility finding is supported by  
20 substantial evidence in the record, the reviewing court "may not  
21 engage in second-guessing." Thomas, 278 F.3d at 959.

## 22 2. Relevant background

### 23 a. *Plaintiff's Allegations*

24 Plaintiff completed an Adult Function Report on April 30,  
25 2013. (AR 226-37.) She alleged being unable to work because of  
26 "excruciating" pain that inhibited her ability to lift, stand,  
27 walk, or bend over; the pain was located in her lower back, legs,  
28 buttocks, knees, feet, shoulders, arms, fingers, toes, neck, and



1 head. (AR 226, 236.) She could do such things as dress and  
2 bathe only "as pain allow[ed]" and had trouble sleeping. (AR  
3 227.) She nonetheless took care of her disabled husband, two  
4 sons, cat, and dog. (Id.) She reported preparing her own meals  
5 daily with help from her family (AR 228), doing "small" household  
6 chores (id.; see also AR 236 ("folding laundry, light dusting,  
7 wiping down counter[, and . . . cooking")), going outside "a  
8 lot" to sit on the grass (AR 229), driving a car (id.), going out  
9 alone (id.), shopping in stores using an electric cart and with  
10 the help of family (AR 229, 236), and being able to pay bills,  
11 count change, handle a savings account, and use a checkbook or  
12 money order (AR 229).

13 She alleged having problems being "around people" and  
14 claimed to be able to pay attention for only "6 seconds." (AR  
15 231.) She reported, however, that she spent time with others.  
16 (AR 230.) She stayed home with her family, saw her mother and  
17 father "once in a while," talked with her mother on the phone  
18 three times a week, and "text[ed] [her] friends to see how they  
19 [we]re." (Id.) She also took her son to soccer practice once a  
20 week, though she would stay in the car, and she didn't "need  
21 someone to accompany [her]." (AR 230, 236.)

22 At her January 28, 2016 hearing, Plaintiff testified that  
23 she stopped working in July 2011 because she "couldn't walk."  
24 (AR 52.) At that time she experienced "shooting nerve pain" in  
25 her left leg (AR 53) and later had surgery for her back (AR 56-  
26 57). The surgery "got rid of a . . . lot of pain," she stated,  
27 but she then "lost all feeling in [her] feet." (AR 57.) She  
28 testified that "most of the feeling" had "come back," however.

1 (Id.)

2 Plaintiff also couldn't "use [her] right hand" (AR 57-58),  
3 experienced "migraine headaches" caused by pain shooting from her  
4 arm up to her neck and "across [her] face" (AR 59), and had  
5 problems with her knees (AR 58). When asked if one knee was  
6 worse than the other, she stated that "it used to be the right  
7 but it's now the left." (AR 58-59.) Because of her physical  
8 impairments, she testified, she could sit for only "five minutes  
9 without shifting," stand for only "10-15 minutes" without sitting  
10 down or changing position, and walk only "about three blocks"  
11 before having to rest for a "few minutes." (AR 60-61.) She  
12 could also lift only a gallon of milk.<sup>3</sup> (AR 62.)

13 Plaintiff had problems with her memory as well. (Id.) She  
14 had "little spaces" that she didn't remember, would be "told  
15 stuff that [she didn't] remember being told," and could not read  
16 a book and remember what she had read. (AR 62-63.) She watched  
17 little television because she couldn't focus, and she stayed away  
18 from friends. (AR 63.) She was married and lived with her  
19 husband and two kids, who were 22 and 16. (Id.)

20 When asked about chores, Plaintiff stated that she could  
21 "cook small meals" and drive. (AR 64.) She did not vacuum,  
22 however, and laundry was brought to her and she would "hold it."  
23 (Id.) Chores, she stated, were a "group effort." (Id.)

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27 <sup>3</sup> A gallon of milk weighs approximately eight and a half  
28 pounds. Hernandez v. Colvin, No. 1:12-CV-00330-SMS, 2013 WL  
4041862, at \*9 n.4 (E.D. Cal. Aug. 8, 2013).

1                   b.    *Plaintiff's Statements to Medical*  
2                               *Professionals*

3           In April 2013, Plaintiff's mental condition was evaluated by  
4 a consulting examiner. (AR 333-38.) She drove to the  
5 appointment "by herself" and was "on time." (AR 333.) She  
6 reported living with four family members. (AR 335.) She could  
7 take care of "self-dressing, self-bathing, and personal hygiene";  
8 drive a car; pay bills and handle cash appropriately; go out  
9 alone; and "focus [her] attention." (Id.) She had "excellent or  
10 good" relationships with "family and friends" and had "no  
11 difficulty completing household tasks" or "making her decisions."  
12 (Id.) On a daily basis, she could "dress, bathe, cook, clean and  
13 do light household chores"; manage money; eat breakfast and make  
14 coffee; go grocery shopping and run errands; organize her home;  
15 eat lunch; watch television; do chores around the house; go  
16 outside and "sit with the dogs"; and "shower before going to  
17 bed." (Id.)

18           In May 2015, she reported to one of her own doctors that she  
19 was "able to manage her own medication," "remember[ed]  
20 appointments," "manage[d] finances," and "pa[id] bills without  
21 problem." (AR 486.) She was noted as being "fully ambulatory  
22 and independent in all activities of daily living." (Id.) She  
23 "dr[ove] a car." (AR 487.) She "visit[ed] the gym 3 times a  
24 week" and "follo[wed] a routine of weight training and  
25 cardiovascular exercise." (Id.) She "walked without  
26 assistance," and "[h]er gait was fluid." (Id.) She "was able to  
27 hear and read instructions." (AR 488.)

28           In October and November 2015, she reported to another of her

1 doctors that she had "Power of Attorney over her mother and [was]  
2 trying to help her with legal issues regarding her home." (AR  
3 531, 539, 542, 681.) Her oldest son had "mental health problems  
4 and still live[d] at home," and she was "trying to get him  
5 appropriate medical care." (AR 532.) Her husband was "injured  
6 in 2009 during active duty," had a "cognitive disorder," and was  
7 "not able to drive," and Plaintiff was "his caretaker." (Id.)  
8 He was on disability. (AR 541.) She reported helping "her  
9 mother, her brother, her husband, and herself." (AR 536.) She  
10 also said that she and her youngest son traveled to San Diego to  
11 find her grandmother's grave. (AR 682.) She reported that "the  
12 whole family . . . rallied to care for each other." (AR 683.)  
13 Plaintiff denied any suicide plans or attempts. (AR 530.)<sup>4</sup>

14 Plaintiff's reports of taking care of her husband appear  
15 throughout the record. (See, e.g., AR 328 (Dec. 2012: Plaintiff  
16 reporting "tak[ing] care of her husband who suffer[ed] from PTSD"  
17 and that she "ha[d] additional stress [from] taking care of  
18 him"), 486 (May 2015: "Her husband suffered a back injury while  
19 in the military and is disabled."), 532 (Oct. 2015: stating that  
20 she was "caregiver" for disabled husband).) And she at one point  
21 indicated that her "[h]usband got [a] large stipend for her to be  
22 caregiver." (AR 510 (Feb. 2014).) She also often reported that  
23 she read books (see, e.g., AR 499 (reading ADD book, which became  
24 "[her] new Bible"), 502 (stating that she had questions for her  
25

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26 <sup>4</sup> That same month, however, during one of her aborted  
27 hearings, when the ALJ expressed frustration that Plaintiff had  
28 not yet gotten a proper representative and declined her request  
that he "be gentle" with her, she threatened, "I could leave the  
room and kill myself, okay?" (AR 82.)

1 psychiatrist regarding "meds and [a] book she[ was] reading"),  
2 540 (reading "books about multiple personality"), 633 (discussing  
3 ADHD book and stating that she "derive[d] some benefit from  
4 that")) and was exercising (see, e.g., AR 629 (Mar. 2015:  
5 "exercising 3 times a week"), 487 (May 2015: "visits the gym 3  
6 times a week and follows a routine of weight training and  
7 cardiovascular exercise"))).

8                   c.     *Physical-Health Medical Evidence*

9           Near the start of the relevant period, in September 2011,  
10 Plaintiff complained of pain in her back and left hip and leg.  
11 (AR 424.) A lumbar-spine x-ray at that time revealed "[n]o  
12 evidence of acute fractures, subluxation or significant disc  
13 space narrowing." (AR 373.) In October, she reported being  
14 "frustrated that [the] xray was normal" and continued to have  
15 "mild" lower back pain but "severe" pain in her leg. (AR 421.)  
16 On examination she demonstrated "no abnormality" in her back,  
17 normal extension, negative straight-leg raising, and "intact"  
18 balance and gait. (AR 422.) She was "positive," however, for  
19 posterior tenderness and "left tenderness from L2 to L5" with  
20 palpation. (Id.; see also AR 418-20 (Nov. 2011: "L spine exam  
21 identical to prior notes/encounters").)

22           On November 14, 2011, Plaintiff began seeing orthopedic  
23 surgeon Amir David Tahernia for her back and left-leg pain. (AR  
24 370-71; see also AR 554.) She reported that she experienced pain  
25 after she "overdid it" with "some vigorous activity" while  
26 "vacationing with her family in August" of that year. (See AR  
27 370.) On examination, Dr. Tahernia found no tenderness in her  
28 back, but her range of motion was "[l]imited in all planes" and

1 she had "4/5 hip flexion, knee extension, and weakness on the  
2 left." (AR 371.) Dr. Tahernia ordered an MRI of her lumbar  
3 spine (AR 372), which was completed later that month (AR 466-68).  
4 The MRI revealed that at the "L4-5" disc level she had "mild  
5 decreased disc height loss," "partial disc desiccation," "disc  
6 bulge with . . . mild bilateral ligamentum flavum buckling and  
7 facet arthropathy that contribute[d] to moderate to severe  
8 bilateral subarticular zone stenosis abutting/compressing the  
9 bilateral descending L5 nerve roots and to mild bilateral neural  
10 foraminal narrowing," and "[m]ild bilateral reactive facet  
11 arthropathy." (AR 467.) She also had a disc bulge with "mild  
12 bilateral ligamentum flavum buckling and facet arthropathy" at  
13 the "L5-S1" disc level, which contributed to "mild bilateral  
14 subarticular zone stenosis encroaching upon the bilateral  
15 descending S1 nerve roots." (Id.) Dr. Tahernia reviewed the  
16 results with Plaintiff and recommended her for a "left L5  
17 transforaminal epidural steroid injection." (AR 368.)

18 The injection was administered on December 7, 2011. (AR  
19 366-67.) At her follow-up appointment a month later, Plaintiff  
20 reported that the injection was "helpful," "[o]verall she . . .  
21 improved," and she was "slowly getting back to the gym" and  
22 exercising. (AR 365.) She still had "some intermittent low back  
23 pain," however, and Dr. Tahernia recommended her for more  
24 injections. (Id.) She received one later that month, on January  
25 30, 2012. (AR 363-64.) She reported in February to another  
26 doctor that it "did not help as much" as the first injection.  
27 (AR 415.)

28 Plaintiff next saw Dr. Tahernia in May 2012, complaining of

1 back, left-leg, and neck pain as well as bilateral upper-  
2 extremity paresthesias. (AR 361.) Dr. Tahernia noted that by  
3 that point she had "undergone a full course of left L5" steroid  
4 injections, which were "therapeutic and diagnostic," but she  
5 nonetheless "developed some recurrent back and lower left leg  
6 pain." (Id.) He reviewed Plaintiff's MRI again and conducted a  
7 physical exam, finding "no specific tenderness to palpation in  
8 [her] lumbar spine" but "decreased" sensation along the lateral  
9 aspect of her left leg. (Id.) He found her to be "a candidate"  
10 for "microdecompression L4-5, left-sided" surgery. (AR 362.)  
11 Plaintiff wanted to "consider options" (id.) and did not receive  
12 that surgery until May 2014 (AR 554-55; see also AR 359 (June  
13 2013: "unable to undergo surgery at this time due to family  
14 issues"))).

15 During the rest of 2012, Plaintiff complained of abdominal  
16 pain, various muscle pains on the right side of her body,  
17 "tingling" in her right arm, neck pain, and headaches. (See AR  
18 413-14 (July 2012), 293-94 (Sept. 2012), 297-98 (Sept. 2012).)  
19 In October, she underwent an "EMG" nerve-conduction study, which  
20 revealed "mild ulnar neuropathy" in her right elbow. (AR 299-  
21 300.) In December, she visited an arthritis clinic. (AR 321-  
22 31.) On examination, she demonstrated "normal range of motion"  
23 in her shoulders, no swelling or tenderness in her elbows or  
24 wrists, no pain in her hips with rotation, full range of motion  
25 in her knees, and no swelling or tenderness in her ankles. (AR

1 330.) She was noted as already taking Vicodin,<sup>5</sup> among other  
2 medications (AR 325), and was "restart[ed]" on Effexor<sup>6</sup> to  
3 "control[] her stress level." (AR 331.) An MRI of her cervical  
4 spine was also conducted that month and revealed no evidence of  
5 "stenosis or disc herniation." (AR 464-65.)

6 In May 2013, Plaintiff was evaluated by consulting examiner  
7 Sean To, who specialized in internal medicine, and complained of  
8 neck and back pain and fibromyalgia. (AR 340-47.) Her abdomen  
9 "appear[ed] to be normal" and exhibited "no tenderness to  
10 palpation." (AR 343.) She had "normal" range of motion in her  
11 upper-extremity joints and "mild tenderness to palpation" in her  
12 shoulders, elbows, and trapezius muscles. (Id.) She had  
13 "normal" range of motion in her lower-extremity joints, "mild  
14 tenderness to palpation" in her knees and ankles, and "moderate  
15 tenderness to palpation" in her left hip. (Id.) Her spine  
16 showed "mild tenderness to palpation" and a range of motion, with  
17 "no discernible limitation in any plane." (AR 343-44.) Her  
18 straight-leg-raising test results were "negative," and her hands  
19 and feet revealed "no significant deformities." (AR 344.) She  
20 was able to manipulate the use of a pen "with ease," did not  
21 "restrict the use of either hand during the examination," could

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22  
23 <sup>5</sup> Vicodin is a name-brand version of a narcotic hydrocodone-  
24 acetaminophen product used to relieve moderate to severe pain.  
25 Hydrocodone Combination Products, MedlinePlus, <https://medlineplus.gov/druginfo/meds/a601006.html> (last updated Jan. 15, 2018).

26 <sup>6</sup> Effexor is the name-brand version of venlafaxine, a  
27 selective serotonin and norepinephrine reuptake inhibitor used to  
28 treat depression. See Venlafaxine, MedlinePlus, <https://medlineplus.gov/druginfo/meds/a694020.html> (last updated Dec. 15, 2017).



1 make a fist bilaterally "without difficult[y]," and adequately  
2 achieved "[p]inch positioning." (Id.) She had "5/5" muscle  
3 strength (id.) and a "normal gait" (AR 345). Dr. To concluded  
4 that Plaintiff could lift and carry "50 pounds occasionally and  
5 25 pounds frequently" and stand and walk for up to "6 hours in a  
6 normal 8-hour workday" but otherwise had no limitations or  
7 restrictions. (AR 345-46.)

8 In 2013, she continued to complain of pain in her back, leg,  
9 neck, and arm even though she had apparently attended physical  
10 therapy for two months that year and had epidural injections in  
11 January and May 2013 – all of which provided "no sense of  
12 relief." (See, e.g., AR 358-59 (June 2013).) A June 2013 x-ray  
13 showed an "essentially normal-looking cervical and lumbar spine."  
14 (AR 360.) That same month, however, she demonstrated tenderness  
15 to palpation in her back, pain when extending or rotating her  
16 back, painful but good range of motion in her shoulders, and  
17 normal strength in her upper extremities. (AR 356.) In July, an  
18 MRI of her thoracic spine showed no evidence of stenosis, neural  
19 foraminal narrowing, or disc herniation. (AR 461-63.)

20 In August 2013, Plaintiff also began to complain of pain in  
21 her right knee and noted "concerns about disability, which she  
22 [wanted] addressed." (AR 352.) On examination, she had some  
23 tenderness to palpation of her back and painful back extension  
24 and rotation, but she had "5/5" muscle strength and negative  
25 straight-leg raises bilaterally. (AR 353.) According to the  
26 attending orthopedic physician, Hazmer Cassim, there was no  
27 "clear-cut evidence of fibromyalgia," and Plaintiff's "many  
28 subjective complaints of pain exceed[ed] objective findings."

1 (Id.) Dr. Cassim also examined her knees that month, following a  
2 complaint that her left knee began to hurt as much as the right;  
3 he noted that a "[f]ourteen-point review of systems" was  
4 "unremarkable," she had full range of motion in both knees, and  
5 she had "mild palpable tenderness" in her right knee but no  
6 tenderness in her left. (AR 349-51.) An x-ray of her knees  
7 conducted at that time showed "some very slight patellofemoral  
8 degenerative joint disease bilaterally" and a "small effusion on  
9 [her] right knee" but was "otherwise unremarkable." (AR 350; see  
10 also AR 460 (Oct. 2013 MRI of left knee showing "subcentimeter  
11 focus of superficial chondral fissure formation and fibrillation  
12 overlying the median eminence of the patella" but "[o]therwise  
13 normal" results).) In November 2013, she was diagnosed with  
14 "[p]atellofemoral syndrome bilaterally[,] right greater [than]  
15 left." (AR 582-83.)

16 Plaintiff's physical-health medical records from 2014  
17 primarily concern her decompression surgery in May 2014. (AR  
18 554-55.) Following the procedure, Plaintiff reported "doing much  
19 better" and was "increasing her activities." (AR 646.) She was  
20 continued on antiinflammatory medication, Flexeril,<sup>7</sup> and Vicodin.  
21 (Id.) An MRI of her lumbar spine completed in August 2014 showed  
22 "no evidence for spinal canal stenosis or disc herniation"; mild  
23 bilateral foraminal narrowing at the L4-L5 level, "consistent for  
24 lumbar spine decompression surgery"; and "reactive changes" at  
25 the "L2-L3, L3-L4, and L4-L5" levels, which "could represent

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26  
27 <sup>7</sup> Flexeril is a name-brand version of cyclobenzaprine, a  
28 skeletal muscle relaxant used to relieve pain. Cyclobenzaprine,  
MedlinePlus, <https://medlineplus.gov/druginfo/meds/a682514.html>  
(last updated Feb. 15, 2017).

1 specific pain generators in the appropriate clinical setting."  
2 (AR 569-71.)

3 She was next seen in June 2015 for pain and numbness in her  
4 left leg and foot and right knee. (AR 575-76, 642-43.) She  
5 demonstrated "decreased sensation" over her foot on examination;  
6 based on a CT scan apparently conducted in March 2015, there was  
7 no evidence of nerve compression in her right or left knee. (AR  
8 642-43.) She was assessed with a "possible" left-toe cyst as  
9 well as "[l]eft leg radicular pain and neuropathy." (Id.; see  
10 also AR 580-81 (assessing Plaintiff with "[s]oft tissue mass [on  
11 the] plantar aspect of [left] toe").) She was seen again in July  
12 2015 for "multi-site pain," and on examination she demonstrated  
13 some tenderness to palpation of her low back, pain while  
14 extending and rotating her back, "greater than 3/5" functional  
15 strength, and "[n]ormal" gait. (AR 577-79, 644-45.) There was  
16 no "clear-cut etiology for her symptoms." (AR 645.)

17 In October 2015, Plaintiff received a neurosurgical  
18 consultation. (AR 647-48.) She was noted as having  
19 "paresthesias in the left lateral foot and right ulnar  
20 distribution" but "equal and symmetrical" deep tendon reflexes,  
21 no pathological reflexes, and "symmetrical" gait. (AR 648.)  
22 Plaintiff's August 2014 lumbar-spine MRI was also reviewed, which  
23 showed no significant stenosis and "mild" disc bulges. (Id.)  
24 The bulges "d[id] not represent [a] severe enough problem to be  
25 causing [Plaintiff's] current symptoms" and were "somewhat more  
26 eccentric to the right at L4-5" even though her "symptoms [were]  
27 on the left." (Id.) She was nonetheless informed that she would  
28 "potentially benefit" from "sciatic nerve decompression at the

1 pelvic outlet" and "perineal nerve decompression at the fibular  
2 head." (Id.)

3 In December 2015, Plaintiff was seen by Dr. A. Nabet for  
4 pain in her right arm and shoulder. (AR 658-61.) She  
5 demonstrated no tenderness in her neck, spine, shoulders, elbows,  
6 or wrists and "intact" range of motion in her extremities. (AR  
7 660.) An MRI of her right shoulder was ordered (AR 661) and was  
8 completed in January 2016 (AR 650-51). It indicated "mild  
9 findings" for bursitis and tendinosis. (AR 651.) Upon review of  
10 the MRI results and on examination, during which Plaintiff  
11 demonstrated pain and tenderness in her shoulders and right  
12 elbow, she was assessed with peripheral nerve-entrapment syndrome  
13 in her right elbow and lower left leg. (AR 655.) She  
14 demonstrated no tenderness in her neck, spine, or abdomen,  
15 however. (Id.) That same month, Dr. Nabet completed a physical  
16 RFC questionnaire and assessed that Plaintiff "constantly"  
17 experienced pain "severe enough to interfere with attention and  
18 concentration" and was "incapable of even 'low stress' jobs,"  
19 among other limitations. (AR 663; see generally AR 662-66.)

20 At Plaintiff's January 2016 hearing, orthopedic surgeon Eric  
21 Schmitter testified as a medical expert. (See AR 43-52.) After  
22 reviewing the record, he found that there was no "significant  
23 orthopaedic pathology of note" (AR 44) and concluded that  
24 Plaintiff did not have less than a "medium" RFC (AR 45). In  
25 support of his findings, he testified that a lumbar-spine MRI  
26 from August 2014 "showed no evidence of stenosis," a right-  
27 shoulder MRI from January 2016 "showed mild bursitis and  
28 tendinitis," "[e]lectrodiagnostic studies showed some mild ulnar

1 changes at the right elbow but nothing of great significance,"  
2 and an April 2013 internal-medicine exam "had no objective spine  
3 findings." (AR 44.) Moreover, the "mild ulnar s[h]owing at the  
4 right elbow" was a "common finding," and another examination  
5 indicated "normal nerve[s]." (AR 46 (citing AR 637-46).) Thus,  
6 "there [was] no evidence that there [was] significant sensory or  
7 motor deficit" (id.) and there were no records finding "any  
8 neurological deficits at all on . . . physical examin[ation]" (AR  
9 51).

10 When asked about fibromyalgia, which Dr. Schmitter opined  
11 was the "probable cause of all of her symptoms," he testified  
12 that there was no "documentation to substantiate" that diagnosis.  
13 (AR 44-45 (finding no record with requisite pressure points).)  
14 When asked about a lumbar-spine MRI referenced by Dr. Tahernia in  
15 May 2012 (see AR 49 (citing AR 362)), Dr. Schmitter stated that  
16 there was no "examination evidence that there[ was] a L5  
17 deficit," such as "muscle weakness or dermatomal sensory loss"  
18 (id.). Impressions of stenosis and radiculopathy were "potential  
19 problems" without "evidence that there [was] a neurologic  
20 deficit." (AR 50.) When asked about a November 2011 MRI of  
21 Plaintiff's lumbar spine, Dr. Schmitter stated that it was "as  
22 normal as you can get." (AR 50-51 (citing AR 466).) Plaintiff's  
23 attorney noted that the MRI found some "compression in the  
24 bilateral descending L5 nerve root," and Dr. Schmitter responded  
25 that that was only a "potential problem." (AR 51; see also AR  
26 467.) He testified that "[i]f there were pressure on the L5  
27 nerve root on the left, there should be corresponding examination  
28 findings resulting in L5 motor weakness . . . [a]nd that's not

1 evident anywhere in the records." (Id.) Dr. Schmitter was also  
2 asked about the decompression surgery that Plaintiff underwent in  
3 May 2014. (Id.) He indicated that there was no basis in the  
4 record to support that surgery. (AR 52.)

5 d. *Mental-Health Medical Evidence*

6 i. *Dr. Bassanelli*

7 Plaintiff began seeing psychiatrist Anthony Bassanelli on  
8 January 15, 2014. (AR 512-19; see also AR 548.) At that time,  
9 she appeared "anxious," but she was oriented and stable and  
10 exhibited "[a]bove [a]verage" intelligence and "good" memory.  
11 (AR 517.) Though her thought forms were circumstantial and  
12 involved loose associations, her thought content was logical and  
13 reality based. (AR 517-18.) He assessed her with "PTSD"<sup>8</sup> and  
14 "ADHD" (AR 518), assigned her a Global Assessment of Functioning  
15 score of 55 (AR 519),<sup>9</sup> and prescribed Effexor (id.). She had  
16

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17 <sup>8</sup> Plaintiff's posttraumatic stress disorder was noted by one  
18 psychologist as being "due to multiple factors," including "the  
19 death of her father" from cancer in 2013. (AR 684; see also AR  
20 681-82 ("It was very traumatic [and] 'brutal' for [Plaintiff] to  
watch her father . . . die[.]"), 683-84 (describing Plaintiff's  
"trauma history").)

21 <sup>9</sup> A GAF score of 51 to 60 indicates moderate symptoms in one  
22 area or difficulty in social, occupational, or school  
23 functioning. See Diagnostic and Statistical Manual of Mental  
24 Disorders 32 (revised 4th ed. 2000). The Commissioner has  
25 declined to endorse GAF scores, Revised Medical Criteria for  
26 Evaluating Mental Disorders and Traumatic Brain Injury, 65 Fed.  
27 Reg. 50764-65 (Aug. 21, 2000) (codified at 20 C.F.R. pt. 404)  
28 (GAF score "does not have a direct correlation to the severity  
requirements in our mental disorders listings"), and the most  
recent edition of the DSM "dropped" the GAF scale, citing its  
lack of conceptual clarity and questionable psychological  
measurements in practice, Diagnostic and Statistical Manual of  
Mental Disorders 16 (5th ed. 2012). Because GAF scores continue  
to be included in claimant medical records, however, the Social  
Security Administration has clarified that they are "medical

1 been using Effexor previously and stated that it "helped[, ] even  
2 [with] whole body pain." (AR 513.)

3 Plaintiff followed up with Dr. Bassanelli in February 2014.  
4 (AR 510.) She stated that her "[h]usband got [a] large stipend  
5 for her to be caregiver" and that she was "feeling a little  
6 better," though "sleep remain[ed] a big problem," and she was  
7 noted as being "pleasant," "animated," "calmer," and "more  
8 focused." (Id.) She was compliant with her medication, and Dr.  
9 Bassanelli made no change because "she like[d] how she [was]  
10 feeling [and] want[ed] to remain at this dose for now." (Id.)  
11 The following month, however, Plaintiff reported being frustrated  
12 because her "current dose of Effexor [was] not as effective" and  
13 her "response to meds" decreased. (AR 509.) Dr. Bassanelli  
14 noted no change in her health and started her on Adderall.<sup>10</sup>  
15 (Id.)

16 By April 2014, Plaintiff had stopped using Effexor because  
17 it caused "blurry vision." (AR 507; see also AR 508.) She

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18  
19 opinion evidence under 20 C.F.R. §§ 404.1527(a)(2) and  
20 416.927(a)(2) if they come from an acceptable medical source."  
21 Wellington v. Berryhill, 878 F.3d 867, 871 n.1 (9th Cir. 2017)  
22 (citing Richard C. Ruskell, Social Security Disability Claims  
23 Handbook § 2:15 n.40 (2017)). As with other medical-opinion  
24 evidence, the reliability of a GAF score depends on whether it is  
25 "consistent with the other evidence, the rater's familiarity with  
the claimant, and the credentials of the rater"; GAF scores  
"should not be considered in isolation." Ruskell, supra, § 2:15  
n.40 (citing internal Social Security Administrative Message  
number 13066, which became effective July 22, 2013, and was  
revised on Oct. 14, 2014).

26 <sup>10</sup> Adderall is the name-brand version of a dextroamphetamine  
27 and amphetamine combination product, a central-nervous-system  
28 stimulant used to control the symptoms of ADHD. See  
Dextroamphetamine and Amphetamine, MedlinePlus, [https://  
medlineplus.gov/druginfo/meds/a601234.html](https://medlineplus.gov/druginfo/meds/a601234.html) (last updated Sept.  
15, 2017).

1 reported being compliant with Adderall and said "she was able to  
2 be much more productive" on it. (AR 507.) She stated, however,  
3 that there were "too many side effects" from it, as she felt too  
4 "wired" and "speeded [sic] up." (Id.) Dr. Bassanelli started  
5 her on Vyvanse.<sup>11</sup> (Id.) A few weeks later, however, Plaintiff  
6 reported feeling "horrible," so Dr. Bassanelli discontinued it  
7 and prescribed her Diazepam "as needed for now."<sup>12</sup> (See AR 506.)

8 In June 2014, Plaintiff reported being "anxious but  
9 managing," and Dr. Bassanelli noted that she was "pleasant" and  
10 "not racing or pressured." (AR 505.) She requested "to go back  
11 [and] retry [Effexor]" and was cautioned about its blurred-vision  
12 side effect. (Id.) She was noted as being compliant with  
13 Diazepam, which had "fair" efficacy, and was restarted on  
14 Effexor. (Id.) She reported that her "zombie" behavior "went  
15 away" but her sleeping was "still awful." (AR 504.) By July,  
16 however, she was "frustrated" with her medications and began  
17 using "natural supplements." (AR 501; see also AR 500 (Aug.  
18 2014: "continuing to manage as 'naturally' as possible").) At  
19 her November 2014 visit, Plaintiff continued to remain off  
20 psychiatric medication, and she reported to Dr. Bassanelli that  
21 she was reading an "ADD book" he had recommended to her, which  
22 became "[her] new Bible." (AR 499.) They discussed the book  
23

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24 <sup>11</sup> Vyvanse is the name-brand version of lisdexamfetamine, a  
25 central-nervous-system stimulant used to control symptoms of  
26 ADHD. Lisdexamfetamine, MedlinePlus, <https://medlineplus.gov/druginfo/meds/a607047.html> (last updated Aug. 15, 2016).

27 <sup>12</sup> Diazepam is used to relieve anxiety, muscle spasms, and  
28 seizures. See Diazepam, MedlinePlus, <https://medlineplus.gov/druginfo/meds/a682047.html> (last updated Apr. 15, 2017).



1 again in January 2015, and she reported "deriv[ing] some benefit  
2 from that." (AR 633.)

3 Throughout 2015, Dr. Bassanelli frequently noted that  
4 Plaintiff's cognition and recent and remote memory were "intact"  
5 and her thoughts were "goal-directed, logical and reality based"  
6 despite some observations of "poor concentration" or "anxious"  
7 mood. (See, e.g., AR 635 (Jan. 2015), 631 (Mar. 2015), 627  
8 (same), 623 (Apr. 2015), 619 (May 2015), 615 (same), 608 (Aug.  
9 2015), 604 (Sept. 2015), 600 (same).) Dr. Bassanelli referred  
10 Plaintiff for neuropsychological testing regarding her alleged  
11 problems with memory and learning (see AR 619-20; see also AR 606  
12 ("[Plaintiff] is very focused on getting validation there is a  
13 real problem with [her] memory."), and that testing was completed  
14 in May 2015 by psychologist Anita Chatigny. (AR 484-96.)

15 Dr. Chatigny subjected Plaintiff to a variety of  
16 psychological tests (see AR 488-91) and found that she had an  
17 overall "[n]ormal" neuropsychological profile with the "capacity  
18 for full independence across all arenas of cognition as well as  
19 capacity for memory and new learning." (AR 492.) She also had  
20 "broad integrity of brain function and intellectual/cognitive  
21 abilities that are commensurate with the majority of others of  
22 similar age." (AR 488, 492.) Indeed, Dr. Chatigny noted that  
23 Plaintiff's "cognitive aptitude [was] higher than these scores  
24 would suggest." (AR 488.) There was, however, some indication  
25 of "diminished attention/concentration," which was "congruent  
26 with [a] diagnosis of Attention Deficit Disorder." (AR 491,  
27 493.)

28 Dr. Bassanelli completed a mental RFC questionnaire in

1 December 2015. (See AR 543-50.) He opined that Plaintiff was  
2 "not capable of any type of employment due to her" mental-health  
3 issues, which included PTSD, "panic and anxiety," and "severe  
4 lack of attention and focus." (AR 550.) She had no "useful  
5 ability" regarding "[m]aintain[ing] attention for two hour  
6 segment[s]" and "[d]eal[ing] with normal work stress" and was  
7 unable to "meet competitive standards" for "[r]emember[ing] work-  
8 like procedures," "[u]nderstand[ing] and remember[ing] very short  
9 and simple instructions," and "[m]aintain[ing] regular  
10 attendance," among other things. (AR 545-46.) But she had the  
11 limited but satisfactory ability to "[c]arry out very short and  
12 simple instructions," "[m]ake simple work-related decisions,"  
13 "[a]sk simple questions or request assistance," "[u]nderstand and  
14 remember detailed instructions," "[c]arry out detailed  
15 instructions," "[i]nteract appropriately with the general  
16 public," and "[m]aintain socially appropriate behavior." (Id.)  
17 She was also "[u]nlimited or [v]ery [g]ood" in her ability to  
18 "[b]e aware of normal hazards and take appropriate precautions,"  
19 "[a]dhere to basic standards of neatness and cleanliness,"  
20 "[t]ravel in unfamiliar place[s]," and "[u]se public  
21 transportation." (Id.)

22 He noted that Plaintiff "carrie[d] notes and her appointment  
23 book with her to remain organized" and "always [came] on time for  
24 her appointments" (AR 549; cf. AR 545 (noting in same report that  
25 she had "[d]ifficulty coming on time for appointments")), but she  
26 tended to be "very anxious" and "irritable" and "struggle[d] in  
27 her interpersonal relationships." (AR 549-50.) Overall, he  
28 noted her prognosis as "[f]air." (AR 543.)

1                   ii. *Dr. Monahan*

2           Plaintiff began seeing psychologist Rosalind Monahan for  
3 psychotherapy in October 2015, on referral from Dr. Bassanelli.  
4 (AR 529-33, 541-42.) At their first visit, they discussed  
5 Plaintiff's mental-health history and prior therapists; Dr.  
6 Monahan noted that she had some memory impairment – but no lack  
7 of concentration – and diagnosed her with PTSD. (AR 541-42.) At  
8 their next visit a week later, they reviewed a homework  
9 assignment completed by Plaintiff, and Plaintiff "shared  
10 info[rmation] re[garding] books about multiple personality . . .  
11 that she [had] read."<sup>13</sup> (AR 540.) Dr. Monahan noted no memory  
12 impairment and no lack of concentration at that time. (*Id.*) The  
13 following day, they met again, Plaintiff shared poetry that she  
14 used to write, and she reported that she had power of attorney  
15 over her mother, who "[was] almost homeless." (AR 539.) Dr.  
16 Monahan noted no memory impairment or lack of concentration at  
17 this or their next meeting. (*Id.*; AR 538.) Dr. Monahan noted  
18 memory impairment but no lack of concentration at each of their  
19 following sessions, however. (AR 537 (Oct. 28, 2015), 536 (Nov.  
20 4, 2015), 535 (Nov. 11, 2015), 534 (Nov. 18, 2015).)

21           In January 2016, Dr. Monahan completed a mental-disorder  
22 evaluation form (AR 668-86), noting that Plaintiff had  
23 "significant memory impairments," "disorganized thinking," and  
24 "paranoia dissociation," among other symptoms (AR 668-69). Dr.  
25 Monahan assessed that she had limited but satisfactory ability to

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26  
27           <sup>13</sup> At her hearing a few months later, Plaintiff claimed to  
28 be unable to "read a book and remember what [she'd] read." (AR  
63.)

1 carry out "very short and simple instructions" and make "simple  
2 work-related decisions" and was unlimited or very good in her  
3 ability to be aware of normal hazards, take appropriate  
4 precautions, and adhere to basic standards of neatness and  
5 cleanliness. (AR 672-73.) But she otherwise was seriously  
6 limited, was unable to meet competitive standards, or had no  
7 useful functional ability in all other aspects of mental  
8 aptitude. (See AR 672-73.) Dr. Monahan indicated that "no  
9 standard tests [were] conducted" to support her findings,  
10 however. (AR 669; see also AR 673 ("No specific tests  
11 performed.")) In a narrative report attached to the  
12 questionnaire, Dr. Monahan opined that based on a total of nine  
13 therapy sessions together (AR 675), Plaintiff had "Dissociative  
14 Identity Disorder with at least one other personality" (AR 684-  
15 87). Dr. Monahan indicated that there was "no exact test to  
16 determine if an individual has DID" and that this could be  
17 "explored further in future sessions." (AR 686.)

18 *iii. Dr. Cross*

19 In April 2013, Plaintiff was evaluated by consulting  
20 psychologist Kara Cross. (AR 333-38.) Plaintiff complained of  
21 anxiety and depression. (AR 333.) On examination, Dr. Cross  
22 found that her thought processes were coherent and organized; her  
23 thought content was relevant, nondelusional, and not in response  
24 to "internal stimuli during the interview"; her mood and affect  
25 were "stable" but "somewhat anxious"; and she was alert and  
26 oriented. (AR 336.) Regarding her memory, Plaintiff was "able  
27 to repeat four digits forward and backward," "recall three items  
28 (House, Ball, Chair) immediately and . . . after five minutes,"

1 and "recall who George Washington was and a school day attended  
2 as a child." (Id.) Regarding her concentration, Plaintiff could  
3 "perform serial threes and serial sevens," knew that "4 dollars  
4 plus 5 dollars is 9 dollars," could "do alpha numeric reasoning,"  
5 and followed the conversation "well." (Id.) Dr. Cross assessed  
6 her with a GAF score of 60 and deemed her condition "good." (AR  
7 337.) She could understand, remember, and carry out "simple one  
8 or two-step job instructions" and "detailed and complex  
9 instructions" and was otherwise "unimpaired" with regard to such  
10 things as interacting with co-workers and the public, maintaining  
11 concentration and attention, and maintaining regular attendance.  
12 (AR 337-38 (emphasis in original).)

### 13 3. Analysis

14 Plaintiff argues that the ALJ improperly discounted her  
15 subjective symptom testimony by basing his analysis on her  
16 activities of daily living and an apparent "lack of treatment  
17 that [was] more aggressive." (J. Stip. at 26-27 (citing AR 29).)  
18 As discussed below, the ALJ erred as to the latter reason but did  
19 not otherwise err in his credibility analysis, offering two clear  
20 and convincing reasons for discounting her testimony:  
21 inconsistency with "activities of daily living" and lack of  
22 "support" in the objective medical evidence.<sup>14</sup> (See AR 29.)

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24 <sup>14</sup> The ALJ provided an additional reason for discounting  
25 Plaintiff's testimony, that there was "no evidence of [muscle]  
26 atrophy." (AR 29.) But the validity of that reason is "open to  
27 question." See Johnson v. Colvin, No. ED CV 15-1992-E, 2016 WL  
28 1532227, at \*4 (C.D. Cal. Apr. 15, 2016); see also Lapeirre-Gutt  
v. Astrue, 382 F. App'x 662, 665 (9th Cir. 2010) (rejecting "lack  
of muscle atrophy" as valid justification for discounting  
plaintiff's testimony because "no medical evidence suggests that  
high inactivity levels necessarily lead to muscle atrophy");

1                   a.   *Daily Activities*

2           An ALJ may properly discount the credibility of a  
3 plaintiff's subjective symptom statements when they are  
4 inconsistent with her daily activities. See Molina, 674 F.3d at  
5 1112. "Even where those [daily] activities suggest some  
6 difficulty functioning, they may be grounds for discrediting the  
7 claimant's testimony to the extent that they contradict claims of  
8 a totally debilitating impairment." Id. at 1113. The ALJ here  
9 found that Plaintiff "ha[d] engaged in a somewhat normal level of  
10 daily activity and interaction" and that her "ability to  
11 participate in such activities diminishe[d] the credibility of  
12 her allegations of functional limitations." (AR 29); see  
13 Reddick, 157 F.3d at 722 (ALJ may discount subjective symptom  
14 statements when "level of activity [is] inconsistent with  
15 Claimant's claimed limitations").

16           Indeed, with regard to her alleged physical impairments,  
17 Plaintiff averred that she was unable to fully stand, walk, lift,  
18 or bend over (AR 226) or use her right hand or sit for very long  
19 (AR 57-58, 60-61). But the ALJ noted that she engaged in such  
20 activities as "preparing simple meals, driving, [and] shopping in  
21 stores" (AR 29), and those findings were supported by substantial  
22

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23 Valenzuela v. Astrue, 247 F. App'x 927, 929 (9th Cir. 2007) (ALJ  
24 erred in determining that "absence of evidence of muscular  
25 atrophy indicated that [plaintiff's] carpal tunnel syndrome was  
26 not as severe as [he] claimed" because "the record was devoid of  
27 any medical testimony to support that finding"). Here, Dr.  
28 Schmitter testified that one would expect "motor" or "muscle  
weakness" in someone with Plaintiff's complaints (AR 46, 49),  
lending medical support to the ALJ's reasoning. But because  
neither party has challenged or defended the ALJ's reasoning in  
this regard, the Court does not address it.

1 evidence in the record. Plaintiff herself reported and testified  
2 that she prepared her own meals (AR 228), "cook[ed]" (AR 64; see  
3 also AR 236, 335), and made breakfast, coffee, and lunch daily  
4 (see AR 335). She could and did drive a car by herself. (See AR  
5 64, 229, 333, 335, 487.) And she shopped in stores, ran errands,  
6 went out alone, and regularly went outside to sit on the grass  
7 with her dogs. (See AR 229, 236, 335.) She also at one point  
8 during the relevant period traveled to San Diego with only her  
9 16-year-old son. (AR 682.)

10 One examining doctor observed that she was "fully ambulatory  
11 and independent in all activities of daily living" (AR 486), and  
12 she was noted on more than one occasion to be exercising multiple  
13 times a week and engaging in "weight training and cardiovascular"  
14 activity at a gym (AR 487, 629; see also AR 646 (reporting that  
15 she was "increasing her activities" in May 2014)). Plaintiff's  
16 daily activities also involved taking care of her disabled  
17 husband, two children, and mother, over whom she had power of  
18 attorney. (See, e.g., AR 227, 328, 486, 510, 531-32, 536, 539,  
19 542, 681.) The record even reflects that Plaintiff and her  
20 husband, who was receiving disability, got a "stipend" for  
21 Plaintiff to act as his "caretaker." (AR 510.) Moreover, her  
22 function report, in which she described how she couldn't  
23 independently cook or do household chores, was completed in April  
24 2013 (see AR 228 ("family helps" with cooking and "does most of  
25 [the chores]"), the same month she reported to Dr. Cross that she  
26 had "no difficulty completing household tasks" and could cook and  
27 "take care of self-dressing, self-bathing, and personal hygiene"  
28 (see AR 335). Thus, the ALJ properly found that such extensive

1 activities of daily living undermined the credibility of  
2 Plaintiff's subjective symptom statements. See Ronquillo v.  
3 Colvin, No. CV 14-6702 JC, 2015 WL 5768348, at \*7 (C.D. Cal.  
4 Sept. 30, 2015) (ALJ properly discounted plaintiff's credibility  
5 "because the alleged severity of his impairment was not  
6 consistent with [his] admitted level of activity," which included  
7 walking around the block, watching television, preparing meals,  
8 driving a car, shopping in stores, and "exercis[ing] 20 minutes 5  
9 days per week at a moderate or strenuous level"); Thomas v.  
10 Colvin, No. CV 12-09915-VBK, 2013 WL 4517872, at \*2 (C.D. Cal.  
11 Aug. 23, 2013) (ALJ properly discounted pain testimony given that  
12 plaintiff "was able to drive, and drove her father and helped him  
13 to prepare his meals; she engaged in physical therapy exercises  
14 every morning; she volunteered at her church and served breakfast  
15 or worked in a day care center checking the children; [and] she  
16 watched her grandchildren").

17       Regarding her mental impairments, Plaintiff alleged that she  
18 had problems with her memory, concentrating, and being around  
19 people. (AR 62-63, 231.) The ALJ found, however, that she  
20 "pa[id] bills, handl[ed] the finances, t[ook] her son to soccer  
21 practices, and spen[t] time with her family." (AR 29; see also  
22 AR 229 (reporting that she could pay bills, count change, handle  
23 savings account, and use checkbook or money order), 230  
24 (reporting that she spent time with others, stayed home with  
25 family, saw her mother and father "once in a while," talked with  
26 her mother on phone three times a week, texted her "friends" to  
27 see how they were, and drove her son to soccer practice once a  
28 week).) Substantial evidence in the record supported those



1 findings. (Compare AR 231 (reporting in Apr. 2013 that she had  
2 problems "getting along with . . . others"), with AR 335  
3 (reporting that same month to examining psychologist that she  
4 managed money and had "excellent or good" relationships with  
5 "family and friends"), and AR 486 (reporting in Apr. 2015 to  
6 examining psychologist that she "manage[d] finances," "pa[id]  
7 bills without problem," and "remember[ed] appointments"), and AR  
8 549 (treating psychiatrist noting in Oct. 2015 that she always  
9 "carrie[d] notes and her appointment book with her to remain  
10 organized").) Moreover, not only did she spend time with her  
11 family, but she also had the mental capacity for helping her  
12 mother with "legal issues regarding her home" (AR 531) and  
13 endeavoring to get her son "medical care" for his own "mental  
14 health problems" (AR 532).

15       And despite Plaintiff's testimony that she was unable to  
16 read or remember what she had read for more than "6 seconds"  
17 because of her alleged cognitive impairments (see AR 63, 231),  
18 she was noted throughout the record as reading books on mental-  
19 health issues, such as ADD and "multiple personality" (AR 499  
20 (book was "[her] new Bible"), 502, 540, 633; see also AR 488  
21 (examining psychologist noting that she "was able to hear and  
22 read instructions")), and being able to keep appointments and  
23 manage her medications by herself (see, e.g., AR 486; see also AR  
24 335 (Plaintiff reporting that she could "focus [her] attention"  
25 and had "no difficulty making her decisions")). The ALJ  
26 therefore properly discounted Plaintiff's testimony based on her  
27 extensive activities of daily living, and his determination was  
28 supported by substantial evidence in the record. See Womeldorf

1 v. Berryhill, 685 F. App'x 620, 621 (9th Cir. 2017) (upholding  
2 ALJ's discounting of plaintiff's credibility in part because his  
3 activities of daily living "were not entirely consistent with his  
4 claimed inability to engage in social interactions"); Lopez v.  
5 Colvin, No. 1:13-cv-00741-SKO, 2014 WL 3362250, at \*16 (E.D. Cal.  
6 July 8, 2014) (ALJ did not err in discounting plaintiff's  
7 testimony because he "could sustain the concentration and memory  
8 to read, watch two to three hours of television, manage his  
9 personal finances, perform household chores, and prepare meals").

10                   b. *Objective Medical Evidence*

11           Contradiction with evidence in the medical record is a  
12 "sufficient basis" for rejecting a claimant's subjective symptom  
13 testimony. Carmickle v. Comm'r, Soc. Sec. Admin., 533 F.3d 1155,  
14 1161 (9th Cir. 2008); see Morgan v. Comm'r of Soc. Sec. Admin.,  
15 169 F.3d 595, 600 (9th Cir. 1999) (upholding "conflict between  
16 [plaintiff's] testimony of subjective complaints and the  
17 objective medical evidence in the record" as "specific and  
18 substantial" reason undermining credibility). Although a lack of  
19 medical evidence "cannot form the sole basis for discounting pain  
20 testimony, it is a factor that the ALJ can consider in his  
21 credibility analysis." Burch v. Barnhart, 400 F.3d 676, 681 (9th  
22 Cir. 2005); Rollins v. Massanari, 261 F.3d 853, 857 (9th Cir.  
23 2001) (citing § 404.1529(c)(2)).

24           In addition to the clear and convincing reason discussed  
25 above, the ALJ found that Plaintiff's subjective symptom  
26 statements were unsupported by the medical evidence. (AR 29.)  
27 Specifically, despite allegations of pain in her lower back that  
28 allegedly prevented her from working (see AR 56-57, 236),

1 Plaintiff had "only mild findings with regard to her back issues"  
2 (AR 29). For example, as the ALJ noted, medical imaging  
3 throughout the record indicated that Plaintiff's back presented  
4 as either "normal" or "mild[ly]" afflicted. (See id.; see also  
5 AR 373 (Sept. 2011 lumbar-spine x-ray showing "[n]o evidence of  
6 acute fractures, subluxation or significant disc narrowing"),  
7 466-68 (Nov. 2011 MRI of lumbar spine showing "mild" findings at  
8 L4-L5 and L5-S1 disc levels), 464-65 (December 2012 MRI of  
9 cervical spine showing no evidence of "stenosis or disc  
10 herniation"), 461-63 (July 2013 MRI of thoracic spine showing no  
11 evidence of stenosis, neural foraminal narrowing, or disc  
12 herniation).) While findings on examination at times indicated  
13 tenderness to palpation of the back (see, e.g., AR 353, 356, 422,  
14 645), they were also "normal," "mild," or showed negative  
15 straight-leg raises (see AR 29; see also, e.g., AR 422 (Oct.  
16 2011: "no abnormality"), 370-71 (Nov. 2011: no tenderness), 361  
17 (May 2012: "no specific tenderness"), 343-44 (May 2013: "mild  
18 tenderness to palpation" and negative straight-leg raises), 353  
19 (Aug. 2013: negative straight-leg raises)). Moreover, her gait  
20 was frequently noted as "normal." (See, e.g., AR 422 (Oct.  
21 2011), 345 (May 2013), 486-87 (May 2015: "fully ambulatory" and  
22 "fluid" gait).)

23 One orthopedic physician observed that Plaintiff's  
24 "subjective complaints of pain exceed[ed] objective findings"  
25 upon examination (AR 353), and during a neurosurgical  
26 consultation, Plaintiff's lumbar-spine disc bulges were found  
27 "not . . . severe enough . . . to be causing [her] current  
28 symptoms," especially given that her symptoms were on her left

1 side and the bulges were "more eccentric to the right" (AR 648).  
2 Thus, the ALJ's discounting of Plaintiff's complaints of back  
3 pain based on a dearth of supporting evidence in the record was  
4 premised on substantial evidence. Pierce v. Astrue, No. CV 09-  
5 8177 RNB, 2010 WL 2998887, at \*1 (C.D. Cal. July 30, 2010)  
6 ("ALJ's adverse credibility determination was proper because it  
7 was supported by substantial evidence and was sufficiently  
8 specific to permit the Court to conclude that the ALJ did not  
9 arbitrarily discredit plaintiff's subjective testimony."). Even  
10 if alternative interpretations of the medical evidence exist, the  
11 Court will not "second guess" the ALJ's reasonable  
12 interpretation. Huntsman v. Colvin, No. EDCV 13-1300 JC, 2014 WL  
13 808020, at \*9 (C.D. Cal. Feb. 28, 2014) ("[T]he ALJ properly  
14 discounted plaintiff's credibility in part because plaintiff's  
15 pain allegations were not fully corroborated by the objective  
16 medical evidence."); see also Thomas, 278 F.3d at 959.

17 *c. Lack of Aggressive Treatment*

18 As Plaintiff argues (see J. Stip. at 26-27), the ALJ may  
19 have erred in his characterization of the medical record as  
20 demonstrating a "lack of treatment that [was] more aggressive or  
21 [required] additional surgical intervention" (AR 29). Plaintiff  
22 received epidural steroid injections (see AR 358-59, 363-64, 366-  
23 67), was prescribed the narcotic Vicodin (see, e.g. AR 325, 646),  
24 and underwent spinal decompression surgery (see AR 554-55). Such  
25 treatment is aggressive. See Lapeirre-Gutt v. Astrue, 382 F.  
26 App'x 662, 664 (9th Cir. 2010) (treatment with narcotic pain  
27 medication, occipital nerve blocks, trigger-point injections, and  
28 cervical-fusion surgery not conservative); Samaniego v. Astrue,

1 No. EDCV 11-865 JC, 2012 WL 254030, at \*4 (C.D. Cal. Jan. 27,  
2 2012) (treatment not conservative when claimant was treated "on a  
3 continuing basis" with steroid and anesthetic "trigger point  
4 injections," occasional epidural injections, narcotic medication,  
5 and doctor recommended surgery). On the other hand, the medical  
6 expert opined that there appeared to be no medical basis for  
7 Plaintiff's decompression surgery (AR 52), nor did the medical  
8 record support the severity of her alleged symptoms warranting  
9 such aggressive treatment, as discussed above (see AR 353  
10 (Plaintiff's "many subjective complaints of pain exceed[ed]  
11 objective findings"), 648 (lumbar-spine disc bulges "d[id] not  
12 represent severe enough problem to be causing [Plaintiff's]  
13 current symptoms"))).

14        Though the ALJ may have erred as to this reason, he provided  
15 at least two other clear and convincing reasons for discounting  
16 Plaintiff's subjective symptom testimony, inconsistency with  
17 daily activities and lack of support in the objective medical  
18 evidence, and thus any error was harmless. See Larkins v.  
19 Colvin, 674 F. App'x 632, 633 (9th Cir. 2017) (citing Batson v.  
20 Comm'r of Soc. Sec. Admin., 359 F.3d 1190, 1197 (9th Cir. 2004)).  
21 Remand is therefore unwarranted on this ground.

22        B. The ALJ Properly Evaluated the Medical-Opinion Evidence

23        Embedded in her arguments regarding the ALJ's physical- and  
24 mental-impairment severity determinations, Plaintiff includes  
25 challenges to the ALJ's evaluation of the medical-opinion  
26 evidence. (See generally J. Stip.) She specifically contends  
27 that the ALJ erred in rejecting the opinion of Dr. Nabet (see id.  
28 at 20) and accepting the opinions of Drs. Schmitter and To (see

1 id. at 21) with regard to her physical impairments, and in  
2 rejecting the opinions of Drs. Bassanelli and Monahan (see id. at  
3 8-10) and accepting the opinion of Dr. Cross (see id. at 15-17)  
4 as to her mental impairments.

5 1. Applicable law

6 Three types of physicians may offer opinions in Social  
7 Security cases: those who directly treated the plaintiff, those  
8 who examined but did not treat the plaintiff, and those who did  
9 neither. Lester, 81 F.3d at 830. A treating physician's opinion  
10 is generally entitled to more weight than an examining  
11 physician's, and an examining physician's opinion is generally  
12 entitled to more weight than a nonexamining physician's. Id.;  
13 see § 404.1527(c)(1).<sup>15</sup> This is so because treating physicians  
14 are employed to cure and have a greater opportunity to know and  
15 observe the claimant. Smolen, 80 F.3d at 1285. But "the  
16 findings of a nontreating, nonexamining physician can amount to  
17 substantial evidence, so long as other evidence in the record  
18 supports those findings." Saelee v. Chater, 94 F.3d 520, 522

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19  
20 <sup>15</sup> Social Security regulations regarding the evaluation of  
21 opinion evidence were amended effective March 27, 2017. When, as  
22 here, the ALJ's decision is the final decision of the  
23 Commissioner, the reviewing court generally applies the law in  
24 effect at the time of the ALJ's decision. See Lowry v. Astrue,  
25 474 F. App'x 801, 804 n.2 (2d Cir. 2012) (applying version of  
26 regulation in effect at time of ALJ's decision despite subsequent  
27 amendment); Garrett ex rel. Moore v. Barnhart, 366 F.3d 643, 647  
28 (8th Cir. 2004) ("We apply the rules that were in effect at the  
time the Commissioner's decision became final."); Spencer v.  
Colvin, No. 3:15-CV-05925-DWC, 2016 WL 7046848, at \*9 n.4 (W.D.  
Wash. Dec. 1, 2016) ("42 U.S.C. § 405 does not contain any  
express authorization from Congress allowing the Commissioner to  
engage in retroactive rulemaking."). Accordingly, citations to  
20 C.F.R. § 404.1527 are to the version in effect from August 24,  
2012, to March 26, 2017.

1 (9th Cir. 1996) (per curiam) (as amended). Moreover, because a  
2 testifying medical expert is subject to cross-examination, his  
3 opinion may be given greater weight. Andrews v. Shalala, 53 F.3d  
4 1035, 1042 (9th Cir. 1995).

5 The ALJ may disregard a physician's opinion regardless of  
6 whether it is contradicted. Magallanes v. Bowen, 881 F.2d 747,  
7 751 (9th Cir. 1989); see Carmickle, 533 F.3d at 1164. When a  
8 doctor's opinion is not contradicted by other medical-opinion  
9 evidence, however, it may be rejected only for "clear and  
10 convincing" reasons. Magallanes, 881 F.2d at 751; Carmickle, 533  
11 F.3d at 1164 (citing Lester, 81 F.3d at 830-31). When it is  
12 contradicted, the ALJ must provide only "specific and legitimate  
13 reasons" for discounting it. Carmickle, 533 F.3d at 1164 (citing  
14 Lester, 81 F.3d at 830-31). The weight given a treating or  
15 examining physician's opinion, moreover, depends on whether it is  
16 consistent with the record and accompanied by adequate  
17 explanation, among other things. § 404.1527(c)(3)-(6). Those  
18 factors also determine the weight afforded the opinions of  
19 nonexamining physicians. § 404.1527(e). The ALJ considers  
20 findings by state-agency medical consultants and experts as  
21 opinion evidence. Id.

22 Furthermore, "[t]he ALJ need not accept the opinion of any  
23 physician . . . if that opinion is brief, conclusory, and  
24 inadequately supported by clinical findings." Thomas, 278 F.3d  
25 at 957; accord Batson, 359 F.3d at 1195. An ALJ need not recite  
26 "magic words" to reject a physician's opinion or a portion of it;  
27 the court may draw "specific and legitimate inferences" from the  
28 ALJ's opinion. Magallanes, 881 F.2d at 755. "[I]n interpreting

1 the evidence and developing the record, the ALJ does not need to  
2 'discuss every piece of evidence.'" Howard ex rel. Wolff v.  
3 Barnhart, 341 F.3d 1006, 1012 (9th Cir. 2003) (quoting Black v.  
4 Apfel, 143 F.3d 383, 386 (8th Cir. 1998)).

5 The Court must consider the ALJ's decision in the context of  
6 "the entire record as a whole," and if the "'evidence is  
7 susceptible to more than one rational interpretation,' the ALJ's  
8 decision should be upheld." Ryan v. Comm'r of Soc. Sec., 528  
9 F.3d 1194, 1198 (9th Cir. 2008) (citation omitted).

## 10 2. Analysis

11 The ALJ afforded "great weight" to the opinions of Drs.  
12 Schmitter, To, and Cross (AR 26, 31) and "little weight" to Drs.  
13 Nabet's, Bassanelli's, and Monahan's (AR 26, 31-32). As both  
14 parties apparently concede (J. Stip. at 8, 20), the ALJ was  
15 required to provide only a "specific and legitimate reason" for  
16 rejecting the latter, see Carmickle, 533 F.3d at 1164. He did.

### 17 a. *Drs. Nabet, Schmitter, and To*

18 Dr. Nabet opined that Plaintiff "was limited to a narrow  
19 range of sedentary work" (AR 31; see also AR 662-66), while Drs.  
20 Schmitter and To opined that she was instead capable of  
21 performing "medium work" (AR 31; see also AR 45, 340-47). The  
22 ALJ rejected Dr. Nabet's opinion, explaining that it was  
23 inconsistent with Plaintiff's "x-ray examination of the lumbar  
24 spine, which showed normal findings," and "records reflecting  
25 that [her] strength was normal in the lower extremities[] and her  
26 straight leg raise test was negative." (AR 31-32.) Dr. To's  
27 opinion, by comparison, was consistent with the same evidence  
28 (see AR 31), and similarly Dr. Schmitter's opinion was



1 "consistent with the objective medical evidence" – specifically,  
2 an "MRI examination of the lumbar spine, which revealed mild  
3 findings," and "records reflecting that [Plaintiff] exhibited no  
4 lumbar spine tenderness." (Id.) The ALJ afforded those opinions  
5 more weight than Dr. Nabet's. (See id.)

6 Plaintiff contends that the ALJ erred in his analysis  
7 because Dr. Nabet's opinion was "in agreement" with the medical  
8 record while the opinions of Drs. Schmitter and To were not. (J.  
9 Stip. at 20-21.) The ALJ, Plaintiff argues, "cherry-picked"  
10 evidence from the record to support his decision. (Id. at 20.)  
11 The ALJ, however, did not err, and his evaluation of their  
12 opinions was supported by substantial evidence in the record.  
13 See Lester, 81 F.3d at 831 (ALJ may reject medical-source opinion  
14 in favor of conflicting physician's opinion as long as that  
15 determination is "supported by substantial record evidence"  
16 (emphasis in original) (citation omitted)).

17 Dr. Nabet saw Plaintiff in December 2015 and completed her  
18 opinion just a month later.<sup>16</sup> (Compare AR 658-61, with 662-66);  
19 see also Orn v. Astrue, 495 F.3d 625, 631 (9th Cir. 2007)  
20 (factors in assessing physician's opinion include length of  
21 treatment relationship, frequency of examination, and nature and  
22 extent of treatment relationship); accord § 404.1527(c)(2).  
23 Though she assessed Plaintiff with a severely limited, sedentary  
24 RFC, she saw her only for arm and shoulder pain. (See AR 658-  
25 66.) A right-shoulder MRI she ordered at the time showed "mild  
26 findings" of bursitis and tendinosis, and she found some pain and

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27  
28 <sup>16</sup> Although Dr. Nabet stated that she began seeing Plaintiff  
in October 2014 (AR 662), no earlier records support that.

1 tenderness in her shoulders and right elbow. (AR 650-51, 655.)  
2 She found no tenderness in her neck, spine, or abdomen, however  
3 (AR 655, 660), and observed that she had "no difficulty walking"  
4 (AR 652).

5 Despite those findings, she nonetheless concluded that  
6 Plaintiff could not perform "even 'low stress' jobs" or "sit and  
7 stand/walk" for more than two hours in an eight-hour workday.  
8 (See AR 663-64.) But that opinion was inconsistent with  
9 treatment notes throughout the record – including her own, as  
10 pointed out above – demonstrating mild or normal findings (see AR  
11 31; see also AR 373 (Sept. 2011 x-ray revealing "[n]o evidence of  
12 acute fractures, subluxation or significant disc space narrowing"  
13 in lumbar spine), 466-68 (Nov. 2011 MRI revealing "mild decreased  
14 disc height loss," "partial disc desiccation," "disc bulge with  
15 . . . mild bilateral ligamentum flavum buckling," and "[m]ild  
16 bilateral reactive facet arthropathy" in lumbar spine), 299-300  
17 (Oct. 2012 EMG nerve-conduction study revealing "mild ulnar  
18 neuropathy"), 464-65 (Dec. 2012 MRI revealing no "stenosis or  
19 disc herniation" in cervical spine), 360 (June 2013 x-ray  
20 revealing "essentially normal-looking cervical and lumbar  
21 spine"), 461-63 (July 2013 MRI revealing "no evidence [of]  
22 stenosis, neural foraminal narrowing, or disc herniation" in  
23 thoracic spine), 571 (Aug. 2014 MRI revealing "[m]ild bilateral  
24 foraminal narrowing" and "no evidence" of stenosis in lumbar  
25 spine), 650-51 (Jan. 2016 MRI revealing "mild" bursitis and  
26 tendinosis in right shoulder)); Ruckdashel v. Colvin, 672 F.  
27 App'x 745, 745-46 (9th Cir. 2017) (as amended) (finding that ALJ  
28 "provided specific and legitimate reasons, supported by

1 substantial evidence, for rejecting" treating physician's  
2 opinion, including that it was "conclusory" and "contradicted by  
3 the objective medical evidence"); Clay v. Astrue, No. CV 12-1881  
4 RNB, 2013 WL 550494, at \*3 (C.D. Cal. Feb. 11, 2013) ("[T]he ALJ  
5 noted that [treating physician's] conclusions were not adequately  
6 supported by clinical data and diagnostic findings, including  
7 [his] own treatment notes[.]").

8       Indeed, as identified by the ALJ, Plaintiff was frequently  
9 found to have normal strength in her lower extremities and  
10 negative straight-leg raises. (See AR 32; see, e.g., AR 422  
11 (Oct. 2011), 418-20 (Nov. 2011), 297 (Sept. 2012), 313 (Jan.  
12 2013), 344 (May 2013), 356 (June 2013), 353 (Aug. 2013), 582  
13 (Nov. 2013), 645 (July 2015).) The ALJ therefore properly  
14 rejected Dr. Nabet's opinion as inconsistent with the medical  
15 evidence. See Kohansby v. Berryhill, 697 F. App'x 516, 517 (9th  
16 Cir. 2017) (upholding inconsistency with medical evidence as  
17 specific and legitimate reason for rejecting medical opinion  
18 (citing Tommasetti v. Astrue, 533 F.3d 1035, 1041 (9th Cir.  
19 2008))); Bailey v. Colvin, 659 F. App'x 413, 415 (9th Cir. 2016)  
20 (inconsistency with "own treatment records" and objective medical  
21 evidence constitutes "specific and legitimate" reason for  
22 rejecting treating physician's opinion).

23       Dr. To examined Plaintiff in May 2013 and assessed her with  
24 a medium RFC. (See AR 340-47.) On examination, he found that  
25 she had "5/5" muscle strength in her upper and lower extremities  
26 (AR 344), "normal" gait (AR 345), and "negative" straight-leg  
27 raises (AR 344). Those findings were consistent with the medical  
28 evidence of record, as laid out above, and thus the ALJ did not

1 err in his evaluation of Dr. To's opinion.

2 Dr. Schmitter reviewed Plaintiff's medical record and  
3 testified at her January 2016 hearing, finding no "significant  
4 orthopaedic pathology" or support in the record for an RFC that  
5 was less than medium. (AR 43-52.) As discussed by the ALJ, his  
6 opinions were "reasonable and consistent with the objective  
7 medical evidence." (AR 31.) For example, the ALJ identified how  
8 Plaintiff's August 2014 MRI "revealed mild findings" (id.; see  
9 also, e.g., AR 373 (Sept. 2011), 466-68 (Nov. 2011), 299-300  
10 (Oct. 2012), 464-65 (Dec. 2012), 360 (June 2013), 461-63 (July  
11 2013), 569-71 (Aug. 2014), 650-51 (Jan. 2016)), and her treatment  
12 records frequently demonstrated "mild" or no lumbar-spine  
13 tenderness (AR 31; see also, e.g., AR 422 (Oct. 2011), 371 (Nov.  
14 2011), 361 (May 2012), 330 (Dec. 2012), 343 (May 2013), 353 (Aug.  
15 2013), 645 (July 2015), 660 (Dec. 2015), 655 (Jan. 2016)).

16 Plaintiff argues, however, that Dr. Schmitter "completely  
17 ignored" an MRI of her spine indicating facet arthropathy, a disc  
18 bulge, and "moderate to severe" stenosis at the L4-5 disc level  
19 (see AR 466-68 (Nov. 2011)) and an MRI of her spine identifying  
20 "reactive changes" that "could represent specific pain  
21 generators" (see AR 569-71 (Aug. 2014)). (J. Stip. at 18 (citing  
22 AR 361, 467, 570-71).) But Plaintiff is mistaken; Dr. Schmitter  
23 reviewed that evidence (see AR 43 (testifying that he read  
24 exhibits "1 through 26-F," or AR 281 through 661)) and addressed  
25 those specific medical-image findings at the hearing (see AR 47-  
26 52).

27 For instance, Dr. Schmitter explicitly mentioned Plaintiff's  
28 August 2014 MRI in justifying his opinion, stating that it

1 "showed no evidence of stenosis" (AR 44), and discussed the  
2 November 2011 MRI in response to questioning from Plaintiff's  
3 counsel (AR 50-51). He testified that that MRI contained  
4 "normal" findings. (AR 51 (stating that they were "as normal as  
5 you can get").) Moreover, he discussed its note regarding  
6 "compression in the bilateral descending L5 nerve root" and  
7 explained that without corroborating evidence of "neurological  
8 deficits," it was only a "potential problem." (Id.) "If there  
9 were pressure on the L5 nerve root on the left," he stated,  
10 "there should be corresponding examination findings resulting in  
11 L5 motor weakness," but he "could find" none. (Id.) Indeed, as  
12 discussed by the ALJ (AR 31), Dr. Schmitter's opinion was  
13 consistent with medical evidence throughout the record  
14 demonstrating normal muscle strength (see e.g., AR 422, 418-20,  
15 297, 313, 344, 356, 353, 582, 645), lack of or mild spinal  
16 tenderness (see, e.g., AR 422, 371, 361, 330, 343-44, 353, 645,  
17 660, 655), and "mild" imaging results (see, e.g., AR 373, 466-68,  
18 299-300, 464-65, 360, 461-63, 569-71, 650-51). The ALJ was  
19 entitled to rely on the doctor's opinion.

20 Plaintiff points to a June 2015 treatment note indicating  
21 that she had "decreased sensation to light touch and pinprick  
22 over [her left] foot" and argues that Dr. Schmitter also  
23 "ignored" this evidence. (See J. Stip. at 18; AR 643.) But  
24 Plaintiff's argument is misplaced. Though Dr. Schmitter did not  
25 specifically mention the treatment note at the hearing, he  
26 nonetheless indicated that he reviewed the entire record, which  
27 included it. Moreover, the note's significance is questionable.  
28 The attending physician who observed Plaintiff's apparent

1 "decreased sensation" also found that she had a "negative Tinel  
2 sign"<sup>17</sup> and "no evidence of compression of her [peroneal] nerve"  
3 according to a recent CT scan. (AR 643.) The doctor "did not  
4 believe her nerve [was] being compressed" or that "she would  
5 benefit from any decompression" surgery. (Id.) A month later,  
6 Plaintiff was seen again, demonstrated "greater than 3/5"  
7 strength in her lower extremities and "normal" gait, and was  
8 assessed as having no "clear-cut etiology" for her pain symptoms.  
9 (AR 645.)

10 Plaintiff also points to an October 2015 neurosurgical  
11 consultant's "recommendation" for nerve-decompression surgery,  
12 which Dr. Schmitter allegedly also ignored. (See J. Stip. at 19;  
13 AR 647-49.) Dr. Schmitter did not specifically mention that  
14 recommendation at the hearing, but as discussed above, he  
15 indicated that he reviewed the entire record, which included the  
16 neurosurgical consultation. The significance of the evidence is  
17 again questionable. That examining physician reviewed  
18 Plaintiff's August 2014 MRI, which he noted as showing no  
19 "significant stenosis" and only "mild" disc bulges. (AR 648.)  
20 He opined that those bulges "d[id] not represent [a] severe  
21 enough problem to be causing [her] symptoms" and were "more  
22 eccentric to the right at L4-5" even though her "symptoms [were]  
23 on the left." (Id.) Believing her "entire pathology in the left  
24 leg [to be] peripheral in origin," he stated that she "would

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26 <sup>17</sup> The Tinel's sign test indicates that a nerve is  
27 irritated; a positive Tinel's sign occurs when light tapping over  
28 the nerve elicits a tingling sensation. Medical Definition of  
Tinel's Sign, MedinceNet.com, [https://www.medicinenet.com/](https://www.medicinenet.com/script/main/art.asp?articlekey=16687)  
[script/main/art.asp?articlekey=16687](https://www.medicinenet.com/script/main/art.asp?articlekey=16687) (last updated May 13, 2016).

1 potentially benefit" from pelvic and perineal-nerve decompression  
2 surgeries. (*Id.*) He also "advised her of [other] potential  
3 surgical treatment[s]." (AR 648-49.) He did not in fact  
4 "recommend" surgery.

5 Thus, the ALJ's reliance on Dr. Schmitter's opinion was  
6 reasonable and supported by substantial evidence in the record.  
7 The ALJ therefore did not err in his evaluation of the opinions  
8 of Drs. Nabet, To, and Schmitter.

9 b. *Drs. Cross, Bassanelli, and Monahan*

10 Drs. Bassanelli and Monahan completed mental-evaluation  
11 forms indicating that Plaintiff had "severe lack of attention and  
12 focus" and "significant memory impairments" and could not perform  
13 even low-stress jobs (AR 543-50, 668-86), while Dr. Cross opined  
14 that she could understand, remember, and carry out simple as well  
15 as complex instructions and was otherwise "unimpaired" (AR 333-  
16 38). The ALJ rejected the opinions of Drs. Bassanelli and  
17 Monahan because they were inconsistent with "records reflecting  
18 that the claimant's cognition and memory were intact," "her  
19 insight and judgment were appropriate," and her "memory and  
20 impulse control were good, affect was stable, and insight and  
21 judgment were fair." (AR 26-27.) By contrast, Dr. Cross's  
22 opinion was afforded more weight because it was consistent with  
23 the same evidence as well as evidence of her daily activities,  
24 which included "preparing simple meals, driving, shopping in  
25 stores, paying bills, handling the finances, taking her son to  
26 soccer practices, and spending time with her family." (AR 26.)

27 Plaintiff argues that the ALJ erred because Drs. Bassanelli  
28 and Monahan had "long-standing treatment relationships" with her

1 and their opinions were supported by the "evidence as a whole."  
2 (J. Stip. at 8-9.) Dr. Cross's opinion, moreover, was allegedly  
3 inconsistent with the medical evidence (id. at 17), "did not have  
4 the benefit of over two years of treatment records" (id. at 16),  
5 did not involve "detailed psychological testing" (id.), and was  
6 "internally inconsistent" (id.). The ALJ, however, did not err,  
7 and his evaluation of their opinions was supported by substantial  
8 evidence in the record. See Lester, 81 F.3d at 831.

9 As discussed above, inconsistency with objective medical  
10 evidence is a specific and legitimate reason for discounting a  
11 treating physician's opinion, Batson, 359 F.3d at 1195; Kohansby,  
12 697 F. App'x at 517, and the ALJ here properly rejected the  
13 opinions of Drs. Bassanelli and Monahan – and credited Dr.  
14 Cross's – for this reason. Plaintiff's cognition and memory were  
15 frequently noted – often by Drs. Bassanelli and Monahan  
16 themselves – as being "intact" or "good" (see, e.g., AR 391 (Aug.  
17 2013), 517 (Jan. 2014), 635 (Jan. 2015), 631 (Mar. 2015), 627  
18 (same), 623 (Apr. 2015), 619 (May 2015), 615 (same), 608 (Aug.  
19 2015), 604 (Sept. 2015), 600 (same), 538-40 (Oct. 2015)) and her  
20 insight and judgment as "appropriate," "fair," "intact,"  
21 "preserved," "adequate," or "normal" (see, e.g., AR 337 (Apr.  
22 2013), 635 (Jan. 2015), 627 (Mar. 2015), 631 (same), 623 (Apr.  
23 2015), 615 (May 2015), 619 (same), 608 (Aug. 2015), 600 (Sept.  
24 2015), 604 (same)). See Woodmass v. Berryhill, 707 F. App'x 432,  
25 435 (9th Cir. 2017) (inconsistency with own treatment notes and  
26 other medical evidence constitutes "specific and legitimate"  
27 reason for discounting treating physician's opinion).

28 Indeed, in 2015, following a series of psychological tests



1 administered by Dr. Chatigny, Plaintiff was found to have a  
2 normal neuropsychological profile, with the "capacity for full  
3 independence across all arenas of cognition," the "capacity for  
4 memory and new learning," and "broad integrity of brain function  
5 and intellectual/cognitive abilities that [were] commensurate  
6 with the majority of others of similar age." (AR 488, 492.)  
7 Specifically with regard to memory, though inconsistencies were  
8 noted, Plaintiff's performance on "complex tasks of visual and  
9 auditory memory" was "[a]verage" and her acquisition of a "14-  
10 item unrelated word-pair list" was "[a]verage," with "good  
11 learning noted across four learning trials." (AR 490.) Her  
12 immediate and delayed recall of "abstract visual designs" was  
13 "[a]verage." (Id.) In a visual learning task, she could "recall  
14 9 of 10 blocks and accurately note the location of 8 blocks."  
15 (Id.) And her "Auditory and Visual Memory composite index  
16 scores" and "Immediate and Delayed Memory scores" were within the  
17 "[a]verage" range. (Id.)

18 Plaintiff contrasts her 2015 psychological testing with that  
19 completed by Dr. Cross, which she argues was "perfunctory," not  
20 "detailed," and without "the benefit of over two years of  
21 treatment records." (See J. Stip. at 16-17.) But Dr. Cross  
22 completed several tests (see AR 333 ("Testing Administered:  
23 Complete Mental Evaluation"); see also AR 335-37 (tests completed  
24 for memory, fund of knowledge, concentration and calculation,  
25 judgment and reasoning, and similarities and differences)), and  
26 the results of Dr. Cross's and Dr. Chatigny's testing were  
27 consistent with each other, regardless of their different  
28 approaches. (Compare AR 337 (Dr. Cross concluding that

1 Plaintiff's condition was "good"), with AR 492 (Dr. Chatigny  
2 concluding that Plaintiff's neuropsychological profile was  
3 "[n]ormal").) Dr. Cross's examination findings supported her  
4 opinion and provided a legitimate basis for the ALJ's discounting  
5 of Plaintiff's treating physicians, see Batson, 359 F.3d at 1195  
6 (ALJ properly discounted treating physician's opinion in part  
7 because it conflicted with "consultative medical evaluation"  
8 completed by examining physician, who determined that plaintiff  
9 was "objectively able to work"), and it thus is irrelevant that  
10 she completed fewer tests than Dr. Chatigny<sup>18</sup> or that she was  
11 only an examining rather than a treating physician, as Plaintiff  
12 argues, see Thomas, 278 F.3d at 957 ("Although the treating  
13 physician's opinion is given deference, the ALJ may reject the  
14 opinion of a treating physician in favor of a conflicting opinion  
15 of an examining physician if the ALJ makes 'findings setting  
16 forth specific, legitimate reasons for doing so that are based on  
17 substantial evidence in the record.'" (citing Magallanes, 881  
18 F.2d at 751)).

19       Moreover, Dr. Cross's opinion was not internally  
20 inconsistent simply because the GAF score of 60 she assigned  
21 Plaintiff denotes "moderate symptoms" whereas she assessed only  
22 mild limitations. (See J. Stip. at 16.) GAF scores do not have  
23

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24       <sup>18</sup> Dr. Monahan apparently conducted no testing (see AR 529-  
25 42, 668-86; see also AR 669 ("no standard tests conducted" on  
26 "intellectual functioning"), 673 ("no specific tests performed"),  
27 686 (Dr. Monahan acknowledging that she did not employ known  
28 "screening tools" to test Plaintiff for Dissociative Identity  
Disorder but still diagnosed it)) but Plaintiff nonetheless  
argues that her opinion should have been given substantial weight  
(J. Stip. at 9).

1 a "direct correlation" to Social Security severity requirements,  
2 Revised Medical Criteria for Evaluating Mental Disorders and  
3 Traumatic Brain Injury, 65 Fed. Reg. 50764-65 (Aug. 21, 2000)  
4 (codified at 20 C.F.R. pt. 404), and "should not be considered in  
5 isolation." Richard C. Ruskell, Social Security Disability  
6 Claims Handbook § 2:15 n.40 (2017). Moreover, a score of just  
7 one point higher, 61, would indicate "mild" symptoms or "some"  
8 difficulty in social, occupational, or school functioning but  
9 that Plaintiff was "generally functioning pretty well," with  
10 "some meaningful interpersonal relationships." See Diagnostic and  
11 Statistical Manual of Mental Disorders 32 (revised 4th ed. 2000).  
12 As discussed above, Dr. Cross's findings were supported by both  
13 the record and her own examination findings, undermining  
14 Plaintiff's argument that the alleged inconsistency constituted  
15 reversible error.

16 Finally, the ALJ discussed Plaintiff's daily activities (AR  
17 26), which was another specific and legitimate reason for  
18 favoring Dr. Cross's opinion over those of Drs. Bassanelli and  
19 Monahan. See Ghanim v. Colvin, 763 F.3d 1154, 1162 (9th Cir.  
20 2014); Morgan, 169 F.3d at 600-02; Fisher v. Astrue, 429 F. App'x  
21 649, 652 (9th Cir. 2011). Plaintiff herself reported that she  
22 could manage her finances (see AR 229), spend time with family  
23 and friends (see AR 230), and shop in stores (see AR 229). Such  
24 activities were corroborated by similar statements made to her  
25 physicians, who noted that she managed her finances (see, e.g. AR  
26 335, 486), had "excellent or good" relationships with "family and  
27 friends" (see, e.g., AR 335, 683 ("[The] whole family . . .  
28 rallied to care for each other.")), had power of attorney over

1 her mother and helped with "legal issues" (see, e.g., AR 531,  
2 536, 539, 542, 681), was paid to care for her disabled husband  
3 (see, e.g., AR 328, 486, 532, 536), cared for her adult son with  
4 mental issues (see, e.g., AR 532), and read books (see, e.g., AR  
5 499, 502, 540, 633). See Hunt v. Colvin, 954 F. Supp. 2d 1181,  
6 1189-90 (W.D. Wash. 2013) (finding that ALJ's rejection of  
7 consulting examiner's opinion as inconsistent with daily  
8 activities was properly supported by ALJ's citation to  
9 plaintiff's self-reported activities and her report of "similar  
10 tasks during a consultative examination"). Plaintiff has not  
11 challenged the ALJ's reasoning in this regard (see generally J.  
12 Stip.), and these activities stand in sharp contrast to the  
13 doctors' opinions that Plaintiff was incapable of performing even  
14 low-stress jobs.

15 Plaintiff contends that Dr. Cross's opinion should not have  
16 been "construed as substantial evidence" because she was not  
17 provided with any of Plaintiff's medical records (see J. Stip. at  
18 15-16 (citing § 404.1517 and Alcazar v. Comm'r of Soc. Sec., No.  
19 2:15-cv-2203-KJN, 2017 WL 1275293, at \*4 (E.D. Cal. Apr. 4,  
20 2017))), but that argument is unavailing. Section 404.1517  
21 requires only that a consulting examiner be given "necessary  
22 background information" about a claimant's condition. See Uy v.  
23 Colvin, No. 1:13-cv-1210 BAM, 2015 WL 351438, at \*6 (E.D. Cal.  
24 Jan. 26, 2015) ("Social Security regulations do not require that  
25 a consulting physician review all of the claimant's background  
26 records."). In April 2013, when Plaintiff met with Dr. Cross, no  
27 mental-health records from the relevant period up to that point  
28 existed, and few such records existed at all. (See, e.g., AR

1 441-42 (Aug. 2010: earliest record concerning mental health,  
2 physician's assistant noting that Plaintiff's "anxiety seems  
3 better today than in the past"), 398-401 (May 2013: earliest  
4 record from relevant period concerning mental health, noting  
5 Plaintiff's report to family-medicine practitioner of "chronic  
6 anxiety" over her father being "in hospice w[ith] sudden liver  
7 disease").) Moreover, during the examination, Dr. Cross reviewed  
8 Plaintiff's psychiatric history with her, and she recounted never  
9 having been hospitalized for mental-health reasons and that she  
10 had had "counseling services off and on since the age of 4." (AR  
11 334.) Thus, Dr. Cross's failure to review medical records was  
12 not contrary to law. See Cisneros v. Colvin, No. 1:12-cv-0931-  
13 BAM, 2013 WL 5375490, at \*6 (E.D. Cal. Sept. 24, 2013) (no error  
14 when consulting examiner did not review records that were  
15 "irrelevant" or did not "shed much light on the claimant's levels  
16 of function as of [the onset date]"); Guerrero v. Colvin, No.  
17 1:12-cv-1100 GSA, 2013 WL 4517915, at \*6 (E.D. Cal. Aug. 26,  
18 2013) (finding that ALJ properly relied on consulting examiner  
19 who had "legitimate basis for her opinion" despite having  
20 reviewed "no medical records" because she took plaintiff's  
21 medical history and conducted evaluation, and plaintiff "fail[ed]  
22 to identify which relevant records [she] should have reviewed and  
23 how the purported failure to review particular records prejudiced  
24 [the] consultative examination").

25 Viewed another way, "the failure to provide prior records  
26 . . . may be harmless when the record as a whole is considered."  
27 Alcazar, 2017 WL 1275293, at \*4. As already discussed, Dr.  
28 Cross's opinion, though not based on a review of Plaintiff's

1 records, was nonetheless consistent with the results of her own  
2 psychological testing and the objective medical evidence as a  
3 whole. See Castaneda v. Astrue, 344 F. App'x 396, 398 (9th Cir.  
4 2009) (ALJ did not err in relying on consulting examiner's  
5 assessment, which "rested on his own independent examination of  
6 [plaintiff] and was consistent with the record as a whole");  
7 Brown v. Colvin, No. 2:15-cv-0293-KJN, 2016 WL 362232, at \*5  
8 (E.D. Cal. Jan. 29, 2016) (finding that ALJ properly relied on  
9 consulting examiner's opinion because it was supported by "his  
10 own clinical findings," other medical-opinion evidence, and  
11 "medical record as a whole"); Moreno v. Colvin, No. EDCV 12-0747  
12 RNB, 2013 WL 1661566, at \*3 (C.D. Cal. Apr. 16, 2013) (reversal  
13 not warranted because consulting examiner "conducted a thorough  
14 examination resulting in independent clinical findings and  
15 reached an opinion about plaintiff's functional limitations that  
16 was generally consistent with plaintiff's medical record").  
17 Thus, any error was harmless, and Dr. Cross's opinion was  
18 properly considered substantial evidence. See Perry v. Astrue,  
19 No. 2:11-cv-3121-KJN, 2012 WL 6555074, at \*6 (E.D. Cal. Dec. 14,  
20 2012) ("[A]ny failure to provide plaintiff's prior treatment  
21 records to [consulting examiner] was harmless error, because  
22 [treating physician's] records contain minimal clinical findings  
23 concerning plaintiff's mental impairments, and . . . [other  
24 mental-health] records document findings that are generally  
25 consistent with those of [the consulting examiner].")

26       Accordingly, remand is unwarranted on this ground.  
27  
28

1 C. The ALJ Properly Evaluated the Severity of Plaintiff's  
2 Alleged Impairments

3 Plaintiff argues that the ALJ erred in finding her  
4 peripheral nerve-entrapment syndrome "non-severe" (J. Stip. at  
5 19) and in finding no severe mental impairment (id. at 4-8). For  
6 the reasons discussed below, the ALJ did not err in either  
7 regard.

8 1. Applicable law

9 The step-two inquiry is "a de minimis screening device to  
10 dispose of groundless claims." Smolen, 80 F.3d at 1290. The  
11 claimant has the burden to show that she has one or more "severe"  
12 medically determinable impairments that can be expected to result  
13 in death or last for a continuous period of at least 12 months,  
14 as demonstrated by evidence in the form of signs, symptoms, or  
15 laboratory findings. See §§ 404.1505, 404.1520(a)(4)(ii); Ukolov  
16 v. Barnhart, 420 F.3d 1002, 1004-05 (9th Cir. 2005); Bowen v.  
17 Yuckert, 482 U.S. 137, 146 n.5 (1987). A medically determinable  
18 impairment is "severe" if it "significantly limits [the  
19 claimant's] physical or mental ability to do basic work  
20 activities."<sup>19</sup> § 404.1520(c); see also § 404.1521(a). "An  
21 impairment or combination of impairments may be found 'not severe  
22 only if the evidence establishes a slight abnormality that has no  
23 more than a minimal effect on an individual's ability to work.'" Webb v. Barnhart, 433 F.3d 683, 686 (9th Cir. 2005) (quoting

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26 <sup>19</sup> "Basic work activities" include, among other things,  
27 "[p]hysical functions such as walking, standing, sitting,  
28 lifting, pushing, pulling, reaching, carrying, or handling" and  
"[c]apacities for seeing, hearing, and speaking." § 404.1521(b);  
accord Yuckert, 482 U.S. at 141.

1 Smolen, 80 F.3d at 1290 (emphasis in original)). A court must  
2 determine whether substantial evidence in the record supported  
3 the ALJ's finding that a particular impairment was not severe.  
4 Davenport v. Colvin, 608 F. App'x 480, 481 (9th Cir. 2015)  
5 (citing Webb, 433 F.3d at 687); see also Kent v. Astrue, 335 F.  
6 App'x 673, 674 (9th Cir. 2009) (same).

7           2. Analysis

8                   a. *Peripheral Nerve-Entrapment Syndrome*

9           The ALJ found that Plaintiff's "peripheral nerve entrapment  
10 syndrome cause[d] only a slight abnormality that would have no  
11 more than a minimal effect on her ability to work." (AR 24.)  
12 The ALJ reasoned that "no objective medical evidence" showed that  
13 the condition lasted or would last for a "continuous period of  
14 not less than 12 months"; further, the condition was "managed  
15 medically" and "[n]o aggressive treatment was recommended" for  
16 it. (Id.)

17           Plaintiff argues that "the medical evidence and [her]  
18 testimony" supported a finding of severity, specifically  
19 identifying three medical records: a September 2012 diagnosis of  
20 "ulnar neuropathy versus cervical radiculopathy on the right  
21 side" (see AR 297-98); an October 2012 electrodiagnostic study  
22 showing "mild ulnar neuropathy" (see AR 299-300); and a January  
23 2013 treatment note indicating a "positive" Tinel's sign on the  
24 right ulnar nerve (see AR 313). (J. Stip. at 19-20.) As to her  
25 testimony, she stated at her January 2016 hearing that she "had  
26 difficulty using her right arm and hand and experienced burning  
27 pain in her elbow area when writing or typing." (Id. at 20  
28 (citing AR 57-58).)



1       The ALJ, however, correctly found that the objective medical  
2 evidence did not support a finding of severity. Her diagnosis  
3 for peripheral nerve-entrapment syndrome was made in January 2016  
4 by Dr. Nabet. (See AR 655.) Her opinion was properly discounted  
5 by the ALJ, as discussed above; indeed, just a month before that  
6 diagnosis Plaintiff was observed as having no tenderness in her  
7 elbows and "intact" range of motion in her extremities (see AR  
8 660). Moreover, despite the evidence of "mild ulnar neuropathy"  
9 in late 2012 and early 2013, Dr. Schmitter, whose opinion the ALJ  
10 properly afforded great weight, noted that such a finding was  
11 "common." (AR 46 (also indicating that Plaintiff had "normal  
12 nerve examination" in June 2015).) Around that same time,  
13 Plaintiff's December 2012 examination at an arthritis clinic  
14 revealed that she had "normal range of motion" in her upper  
15 extremities and no swelling or tenderness in her elbows or  
16 wrists. (AR 330.) The only treatment she received following  
17 that examination was a prescription for Effexor to control her  
18 "stress level." (AR 331.) Even if Plaintiff had a positive  
19 Tinel's sign in January 2013, nothing in the record indicates  
20 that the nerve irritation lasted for the requisite 12 months, as  
21 the ALJ concluded (AR 24).

22       Though Plaintiff also points to her testimony of difficulty  
23 using her right hand, the ALJ properly discounted her subjective  
24 symptom testimony, as discussed above. And at a consultative  
25 examination in May 2013, she was shown to have grip strength  
26 "commensurate with [normal] motor strength." (AR 344.) She had  
27 "no significant deformities" in her hands, could "manipulate the  
28 use of a pen with ease," did "not restrict the use of either hand

1 during the examination," could "approximate fingers and make a  
2 fist without difficulties bilaterally," and achieved adequate  
3 "[p]inch positioning" bilaterally. (Id.) And as already noted,  
4 her activities of daily living included many things requiring the  
5 use of her hands, such as driving a car (AR 64, 229, 333, 335,  
6 487) and weight-lifting (AR 487 (May 2015)).

7 Substantial evidence therefore supported the ALJ's severity  
8 determination as to Plaintiff's alleged peripheral nerve-  
9 entrapment syndrome. See Delanoy v. Berryhill, 697 F. App'x 917,  
10 919 (9th Cir. 2017) ("The ALJ properly relied on the absence of  
11 record medical evidence sufficient to support a determination  
12 that [plaintiff's] migraines did not cause more than minimal  
13 limitation in [his] ability to perform basic work activities.");  
14 accord Neeley v. Berryhill, 693 F. App'x 641, 642 (9th Cir.  
15 2017).

16 *b. Mental Impairments*

17 The ALJ found that Plaintiff had the "medically determinable  
18 mental impairments of anxiety and depression" but that they did  
19 "not cause more than minimal limitation in [her] ability to  
20 perform basic mental work activities and [were] therefore  
21 nonsevere." (AR 24.) Plaintiff argues that the ALJ improperly  
22 rejected the opinions of Drs. Bassanelli and Monahan to support  
23 his analysis here (see J. Stip. at 8-10), but as discussed above,  
24 the ALJ properly discounted their opinions and correctly afforded  
25 Dr. Cross's opinion "great weight." See Frantz v. Comm'r of Soc.  
26 Sec. Admin., No. CV-16-04048-PHX-GMS, 2017 WL 3188418, at \*4 (D.  
27 Ariz. July 27, 2017) ("The inconsistencies between the objective  
28 medical evidence and [physician's] treating records and his

1 ultimate opinion as well as the contradictions between his  
2 opinion and the findings of the other physicians 'provides  
3 substantial evidence to find that the medical evidence clearly  
4 established the claimant's lack of a medically severe impairment  
5 or combination of impairments.'" (citing Webb, 433 F.3d at 688)  
6 (alterations omitted)).

7 Plaintiff further argues that the ALJ "mischaracterized" the  
8 medical evidence in making his mental severity determination, but  
9 substantial evidence in the record demonstrates that despite her  
10 alleged mental impairments, she had "intact" or "good" cognition  
11 and memory (see, e.g., AR 391 (Aug. 2013), 517 (Jan. 2014), 635  
12 (Jan. 2015), 631 (Mar. 2015), 627 (same), 623 (Apr. 2015), 619  
13 (May 2015), 615 (same), 608 (Aug. 2015), 604 (Sept. 2015), 600  
14 (same), 538-40 (Oct. 2015)) and "appropriate," "fair," "intact,"  
15 "preserved," or "normal" insight and judgment (see, e.g., AR 337  
16 (Apr. 2013), 635 (Jan. 2015), 627 (Mar. 2015), 631 (same), 623  
17 (Apr. 2015), 615 (May 2015), 619 (same), 608 (Aug. 2015), 600  
18 (Sept. 2015), 604 (same)). She also managed her own finances  
19 (see AR 229, 335, 486); spent time with family and friends  
20 (see AR 230, 335); had power of attorney over her mother, whom  
21 she helped with "legal issues" (see, e.g., AR 531, 536, 539, 542,  
22 681); was paid to care for her disabled husband (see, e.g., AR  
23 328, 486, 532, 536); cared for her adult son with mental issues  
24 (see, e.g., AR 532); and read books (see, e.g., AR 499, 502, 540,  
25 633). As the ALJ found, Plaintiff experienced only "mild"  
26 limitations in her activities of daily living, social  
27 functioning, and concentration, persistence, and pace and had  
28 never experienced an episode of decompensation. (AR 25); see

1 Cosgrove v. Berryhill, No. EDCV 16-2551 JC, 2017 WL 5054658, at  
2 \*3 (C.D. Cal. Oct. 31, 2017) (finding that "substantial evidence  
3 support[ed] the ALJ's step two determination" because plaintiff's  
4 daily activities, social functioning, and concentration,  
5 persistence, and pace were at most "mild[ly]" limited and she had  
6 no episodes of decompensation).

7 Accordingly, the ALJ did not err in his severity  
8 determination and remand is unwarranted on this ground.

9 **VI. CONCLUSION**

10 Consistent with the foregoing and under sentence four of 42  
11 U.S.C. § 405(g),<sup>20</sup> IT IS ORDERED that judgment be entered  
12 AFFIRMING the Commissioner's decision, DENYING Plaintiff's  
13 request for remand, and DISMISSING this action with prejudice.

14  
15 DATED: March 29, 2018

  
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16 JEAN ROSENBLUTH  
17 U.S. Magistrate Judge  
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25 \_\_\_\_\_  
26 <sup>20</sup> That sentence provides: "The [district] court shall have  
27 power to enter, upon the pleadings and transcript of the record,  
28 a judgment affirming, modifying, or reversing the decision of the  
Commissioner of Social Security, with or without remanding the  
cause for a rehearing."